

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08390		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08395	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or Print) Quitman Hurley Anstine, Jr.			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> June 23 1968		2b. HOUR 4:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 5, 1925	6. AGE (in years last birthday) 43 YRS.	2c. DATE PRONOUNCED DEAD Month Day Year 19	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) D. O. A. Cambridge Md. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Post Office employee	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 403 Talbot Ave.
14. FATHER'S NAME First Middle Last Quitman Hurley Anstine			15. MOTHER'S MAIDEN NAME First Middle Last Helen Palmer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Mrs. Florence W. Anstine, Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 Mins.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.		M.D.		22b. DATE SIGNED 6/24/68	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE June 25, 1968	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md.		23d. LOCATION (City or Town) (County) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR R. Shouman		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE JUN 28 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

CONFIDENTIAL

403 Taylor Ave.
Mrs. Florence W. Knicker, owner

Serial 22, 1948, Rochester Memorial Hospital, Buffalo, N.Y.

Controlled

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Emerson Leroy Bolden			2a. DATE OF DEATH Month Day Year June 27 1968			2b. HOUR 10 35 P	
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH 6-27-68		6. AGE (In years last birthday) YRS. MONTHS DAYS 1 43	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Finchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Emerson Leroy Smullen Jr.		15. MOTHER'S MAIDEN NAME First Middle Last Gloria Jean Bolden		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None	
17. INFORMANT Address Gloria Bolden Federalsburg, Md., RFD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>7630</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <u>Dr. J. Edwin Fassett</u> attended the deceased from <u>6-27</u> , 19 <u>68</u> , to <u>6-27</u> , 19 <u>68</u> , that (I) <u>did</u> last saw the deceased alive on <u>6-27</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-3-68	
22d. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett				22e. ADDRESS 623 High Street Cambridge, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

81-14917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08332										08397									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) HERMAN					First Middle Last BRAMBLE					2a. DATE OF DEATH Month June Day 22 Year 1968					2b. HOUR M				
3. SEX Male			4. RACE White			5. DATE OF BIRTH Sept. 7, 1892			6. AGE (In years lost birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Dorchester Md.										
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer-net.			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Church Creek			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER None							
14. FATHER'S NAME First Middle Last Noah ? Bramble					15. MOTHER'S MAIDEN NAME First Middle Last Mary ? ?														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, as, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-16-4792			17. INFORMANT Address LeCompte Funerl Service records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 Cerebral Palsy																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 2-17-59 , 19__, to 6-22-68 , 19__, that (I) (we) last saw the deceased alive on 6-22-68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Albert E. Bunker, M. D.										22c. DATE SIGNED 6-24-68									
22d. PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.										22e. ADDRESS 200 Md. Ave., Cambridge, Maryland 21613									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE June 25, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Thomas Churchyard			23d. LOCATION (City or Town) (County) (State) Bishops Head, Maryland										
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR JUL - 1 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge										

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FOR STATE HEALTH-DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08398	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
MABLE H.W. BRAMBLE						JUNE 7 1968			5:30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
FEMALE	WHITE	10-04-92	75 YRS.					JUNE 7 1968			5:30
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			USA						DORCHESTER Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE			EASTERN SHORE STATE HOSPITAL			RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			DORCHESTER			WINGATE					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
JOSEPH HENRY WINGATE			KATHERINE WINGATE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			217-54-5074			RECORDS OF THE EASTERN SHORE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Terminal Pneumonia										3 days	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Fractured neck of femur										8 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
904.7											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5/31 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			Fall in hospital		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			Hospital Cambridge Md. Clos.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			JOHN MACE M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6/7/68		
DEPUTY MEDICAL EXAMINER						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jun 10, 1968			Greenlawn Cemetery			Cambridge, Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
LeCompte Funeral Service, Cambridge, Maryland						JUN 14 1968			Charles Judge		

IN SENATE
January 10, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

38399

1. DECEASED-NAME (Type or print) MARTIN		First M Middle L. Last BRAMBLE		2a. DATE OF DEATH Month June Day 24 Year 1968		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 7, 1871		6. AGE (In years last birthday) 96 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer-trapper		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Robbins		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Zakie Middle ? Last Bramble		15. MOTHER'S MAIDEN NAME First Brigette Middle ? Last ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) -- --		16b. SOCIAL SECURITY NO. unk	
17. INFORMANT LeCompte Funeral Service records		Address LeCompte Funeral Service records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION 2699 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2765 EXTREME AGE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 68 , to 6/24 , 19 68 , that (I) (we) last saw the deceased alive on 6/24 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.E. GURBY JR. M.D.				DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/25/68	
22d. PHYSICIAN'S NAME (Type) W.E. GURBY JR.				22e. ADDRESS Cambridge Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Sandy Island Cemetery		23d. LOCATION (City or Town) (County) (State) Robbins, Dor. Co., Md.	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				ADDRESS LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAIL - 1 1968	
				25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEMORANDUM

TO :

FROM :

SUBJECT :

DATE :

RE :

10-10-55

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10-10-55

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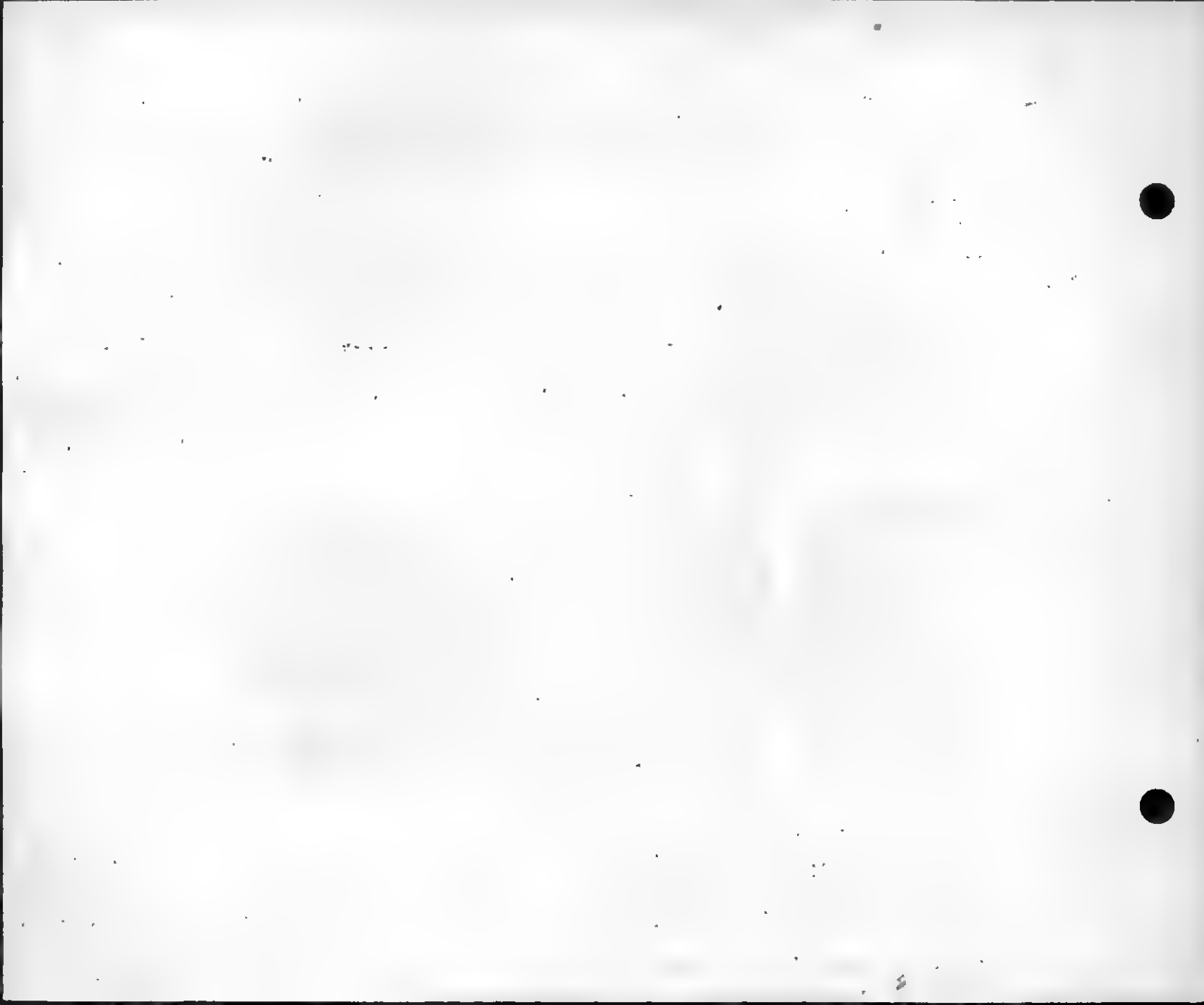
10-10-55

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last John Francis Brimer			2a. DATE OF DEATH JUNE Month 9 Day 68 Year			2b. HOUR 1 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 07-04-88		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Railroad Men		12b. KIND OF BUSINESS OR INDUSTRY Railroad.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 501 Walnut Street	
14. FATHER'S NAME First Middle Last Unknown John -- Brimer			15. MOTHER'S MAIDEN NAME First Middle Last Unknown Martha -- Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no --			16b. SOCIAL SECURITY NO. unk.		17. INFORMANT Address Medical Records - Eastern Shore State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WK										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS AND CHRONIC BRAIN SYNDROME.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8 JUNE, 1968, to 9 JUNE, 1968, that (I) (we) last saw the deceased alive on 9 JUNE 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sean M. Killoran M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9 June 68			
22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN M.D.					22e. ADDRESS 7415 BLAIR RD, WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-11-1968		23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		23d. LOCATION (City or Town) (County) (State) New Church - Accom. -Va.				
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

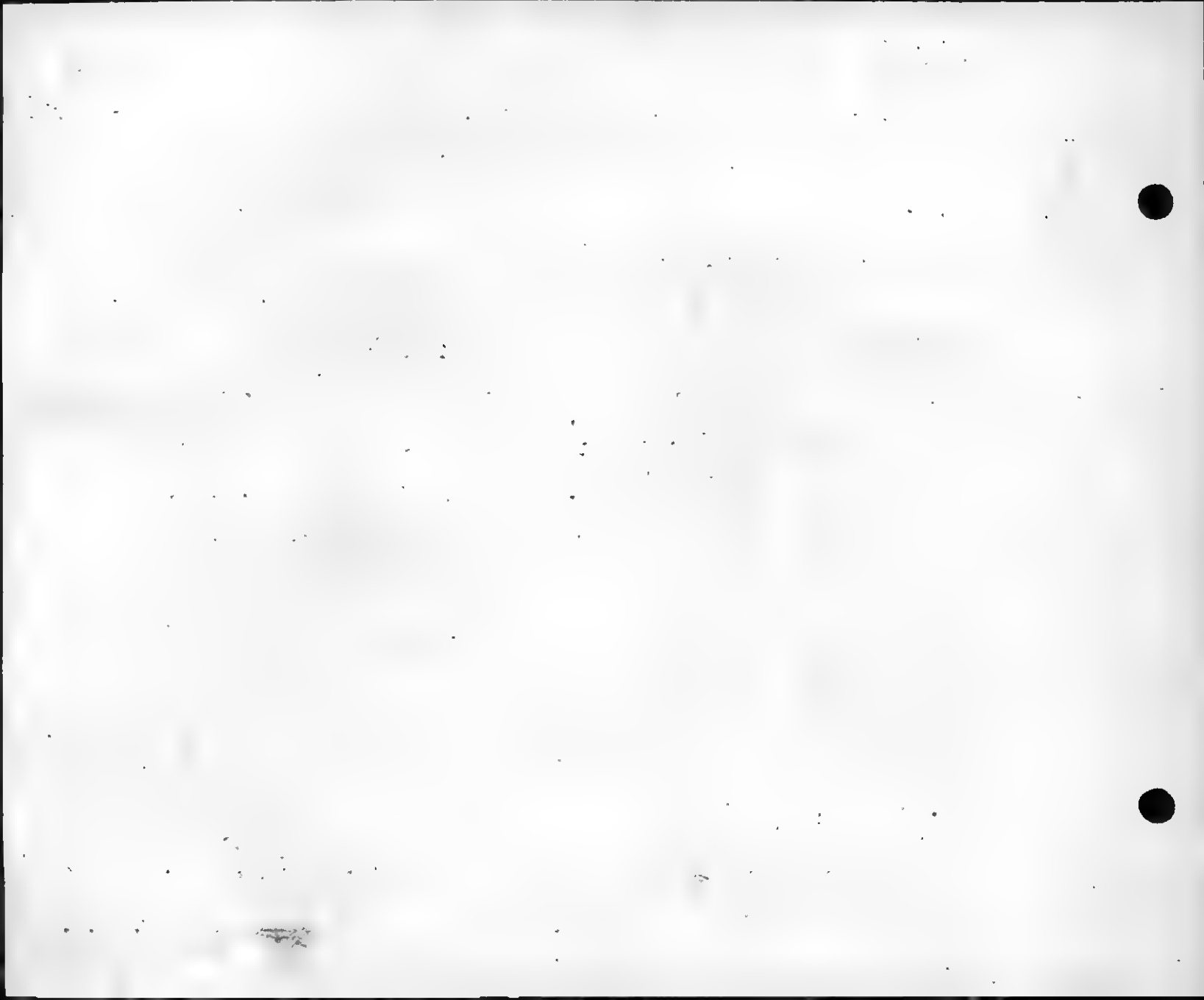


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
304A REV. 1-68

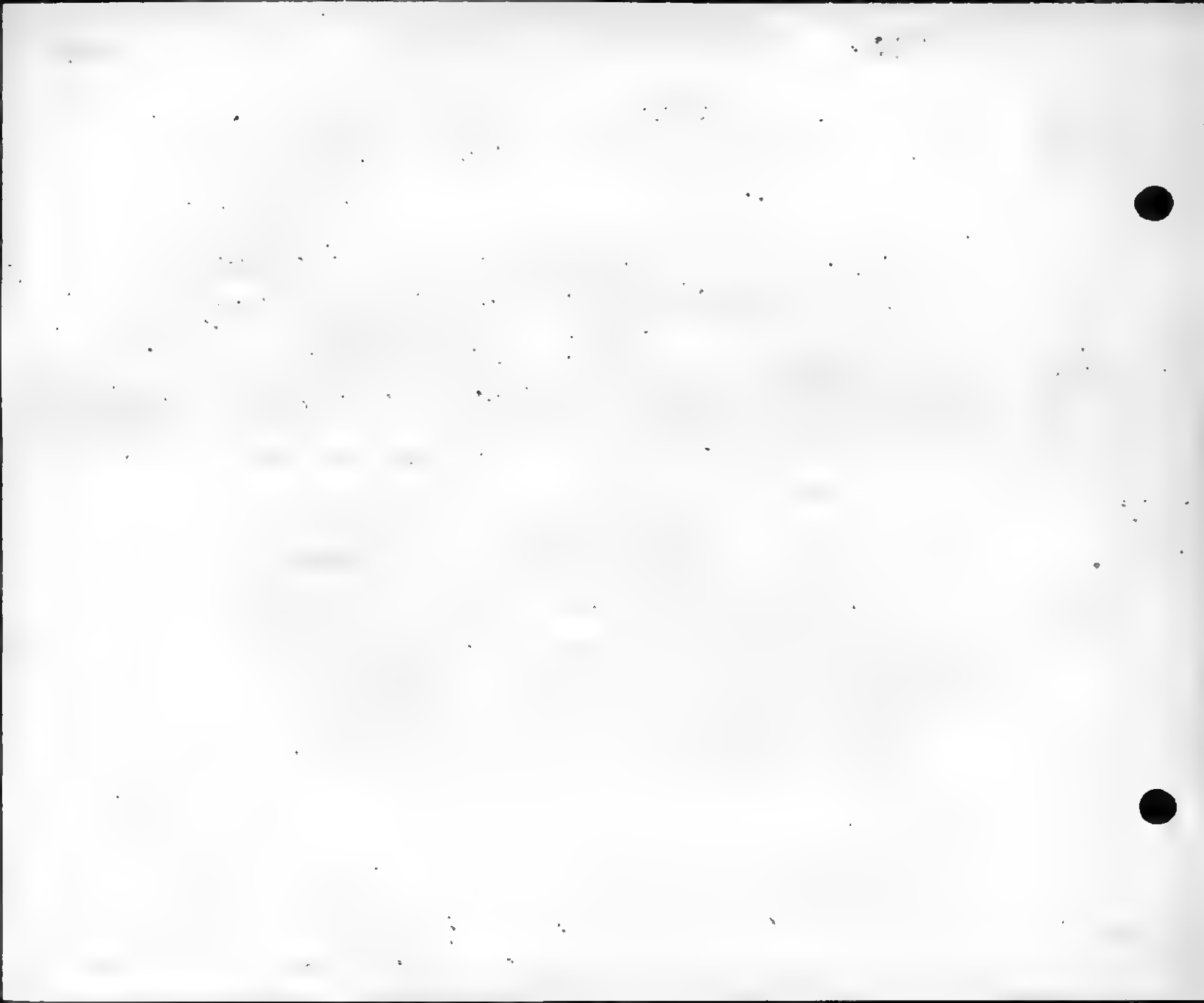
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print) IRVING			First R.			Middle BRYAN			Last			2a. DATE OF DEATH Month 06 Day 30 Year 68			2b. HOJR 5-6-58	
3 SEX Male			4 RACE Negro			5. DATE OF BIRTH 03-25-14			6. AGE (In years last birthday) 54 YRS.			IF UNDER 1 YEAR MONTHS 5 DAYS 4		IF UNDER 24 HRS HOURS 5 MIN 6		
7a. BIRTHPLACE (State or foreign country) md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Dorchester Md.							
10. CITY OR TOWN OF DEATH Rural-Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.			13b. COUNTY DOR.			13c. CITY OR TOWN Cambridge			13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 704 Moore's ave.							
14. FATHER'S NAME First LEONARD			Middle BRYAN			Last			15. MOTHER'S MAIDEN NAME First ELIZABETH			Middle CHESTER			Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO UNKNOWN			17. INFORMANT Med. Records			Address Eastern Shore State Hosp							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with widespread metastases DUE TO, OR AS A CONSEQUENCE OF (c) and bronchopneumonia, left PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 162.1															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE W. Rieckert															22c. DATE SIGNED 6-30-68	
22d. PHYSICIAN'S NAME (Type) W. Rieckert															22e. ADDRESS E. New Market, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7/6/68			23c. NAME OF CEMETERY OR CREMATORY VAUGHN			23d. LOCATION (City or Town) (County) (State) OLDFIELD DOR. MD.							
24. FUNERAL DIRECTOR Frederick C. Delain			ADDRESS CAMBRIDGE, MD			25a. REC'D BY REGISTRAR JUL - 9 1968			25b. REGISTRAR'S SIGNATURE John's Judge							



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Ida</i> <i>Baker</i> <i>Carroll</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>16</i> Year <i>1968</i> <i>9:20 PM</i>			2b. HOUR				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8/11/1878</i>		6. AGE (In years last birthday) <i>89</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i> Md				
10. CITY OR TOWN OF DEATH <i>Cambridge</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Glasgow Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Hurlock</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Academy</i>	
14. FATHER'S NAME First <i>James</i> Middle <i></i> Last <i>Baker</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i></i> Last <i>Towers</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-09-5446</i>		17. INFORMANT <i>Mrs W. F. E. Loftin, Marion, N.C.</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dehydration</i> <i>4019</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic Brown Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke & thrombosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Stroke</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>6</i> Day <i>16</i> Year <i>1968</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <i>9-3</i>		City or Town <i>Cambridge</i>		County <i>Dor.</i> State <i>Md.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-3</i> , 19 <i>67</i> , to <i>6-16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Richard G. Bilodeau</i> DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>6-16-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>RICHARD G. BILODEAU</i>					22e. ADDRESS <i>CAMBRIDGE MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington</i>		23d. LOCATION (City or Town) <i>Hurlock, Dor. Md.</i>		(County) (State)		
24. FUNERAL DIRECTOR <i>Ruth S. Shillingby, East New Market</i> ADDRESS					25a. REC'D BY REGISTRAR DATE <i>JUN 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



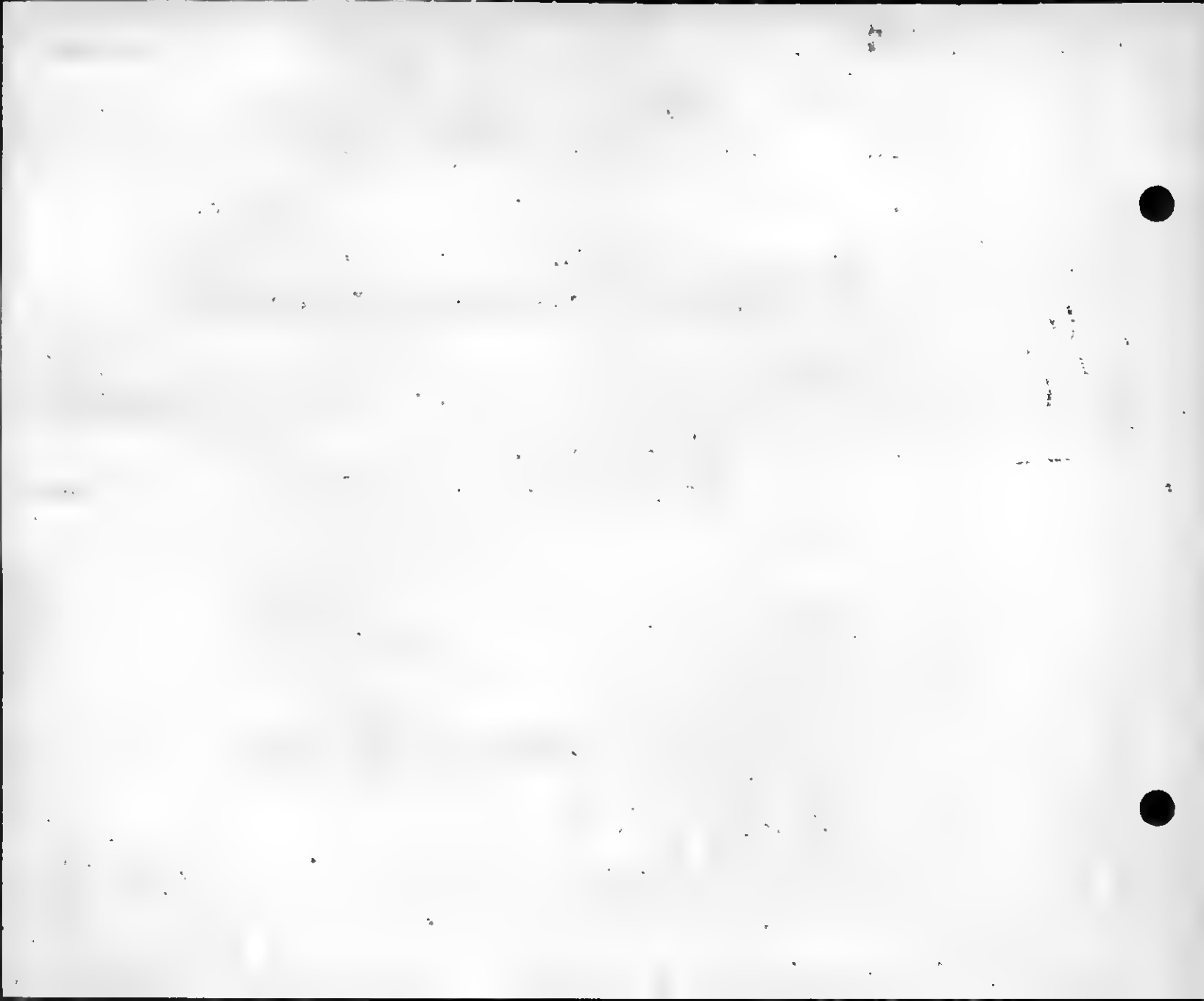
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VR A15 (4)
304A REV 1/68

<div style="text-align: center;"> <p>00398</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First		Middle		Last		Month		Day		Year	
Ruth		Helen		Dayton		June		17		1968	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER MONTHS		YEAR DAYS	
Female		White		March 15, 1930		38		YRS.		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.				Dorchester Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Cambridge				Cambridge-Md. Hospital				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.				St. Marys		Leonardtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #2	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First		Middle		Last		First		Middle		Last	
Russell		G.		Stack		Ruth				Bangert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No						Earl F. Dayton RD 2 Leonardtown Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of right breast with metastases</u>											3 years
DUE TO, OR AS A CONSEQUENCE OF (b) <u>breast with metastases</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
Aug. 1966											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
CA breast											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year											
P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1966 to Jan. 7, 1968, that (I) (we) lost											
saw the deceased alive on June 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the											
causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
Lewis M. Burdette											
22c. DATE SIGNED											
17 June 68											
22d. PHYSICIAN'S NAME (Type)											
Lewis M. Burdette											
22e. ADDRESS											
4 Aurora St. Cambridge, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		6/19/68		E. New Market Cemetery				E. New Market Dor. Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kenneth R. Thoma, Jr.				Cambridge Md.				DATE JUN 26 1968		J. Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10-5-61
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last John Henry Delaha						2a. DATE OF DEATH Month Day Year 6 - 2 - 68			2b. HOUR 2:45 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-19-76		6. AGE (In years last birthday) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sailor - waterman			12b. KIND OF BUSINESS OR INDUSTRY waterman		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Church Creek		13d. INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Henry Delaha				15. MOTHER'S MAIDEN NAME First Middle Last Anna Dzik							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes () or unknown ()		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-22-7826		17. INFORMANT Mrs Nora Wallace		Address Church Creek Md.			
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - PNEUMONITIS 4-5-6-7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 1/2 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) OLD CVA -											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (this hospital) attended the deceased from 12-17-65 to 6-2-68, 19, that (we) last saw the deceased alive on 6-2-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward Lewis						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-2-68			
22d. PHYSICIAN'S NAME (Type) EDWARD LEWIS, M.D.						22e. ADDRESS ESSH, CAMBRIDGE, MD -					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE 6/4/68		23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION (City or Town) East New Market		County Dor.		State Md.	
24. FUNERAL DIRECTOR S. Hollingsby						25. REC'D BY REGISTRAR DATE JUN 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 14. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

50400
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
Ferdinand				Forthman	<input checked="" type="checkbox"/> EST. MATED <input type="checkbox"/>		6-24-	19	68	? M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
M	W	May 15, 1915		53 YRS	MONTHS DAYS		HOURS MIN		Month 6 Day 24 Year 1968	2d. HOUR 12 N	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna		USA		Dorchester					Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during last week)		12b. KIND OF BUSINESS OR INDUSTRY			
near Cambridge						State assessment					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Dorchester		Andrews		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
James		Cora		Baungardner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS							
no				Mrs. Ferdinand Forthman, Andrews, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest										Instant	
955x DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
976x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
2a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21a. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. P.M. 6/24/19 68		Shot self with shotgun							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
		chicken house-home		Andrews		Dor.		Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
John Mace Jr.		John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6/26/68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		June 27, 1968		Sandy Island		Dorchester, Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REG STRAR				25b. REGISTRAR'S SIGNATURE					
Charles V. Moore, Denton, Md.		JUL - 1 1968				Charles Judge					

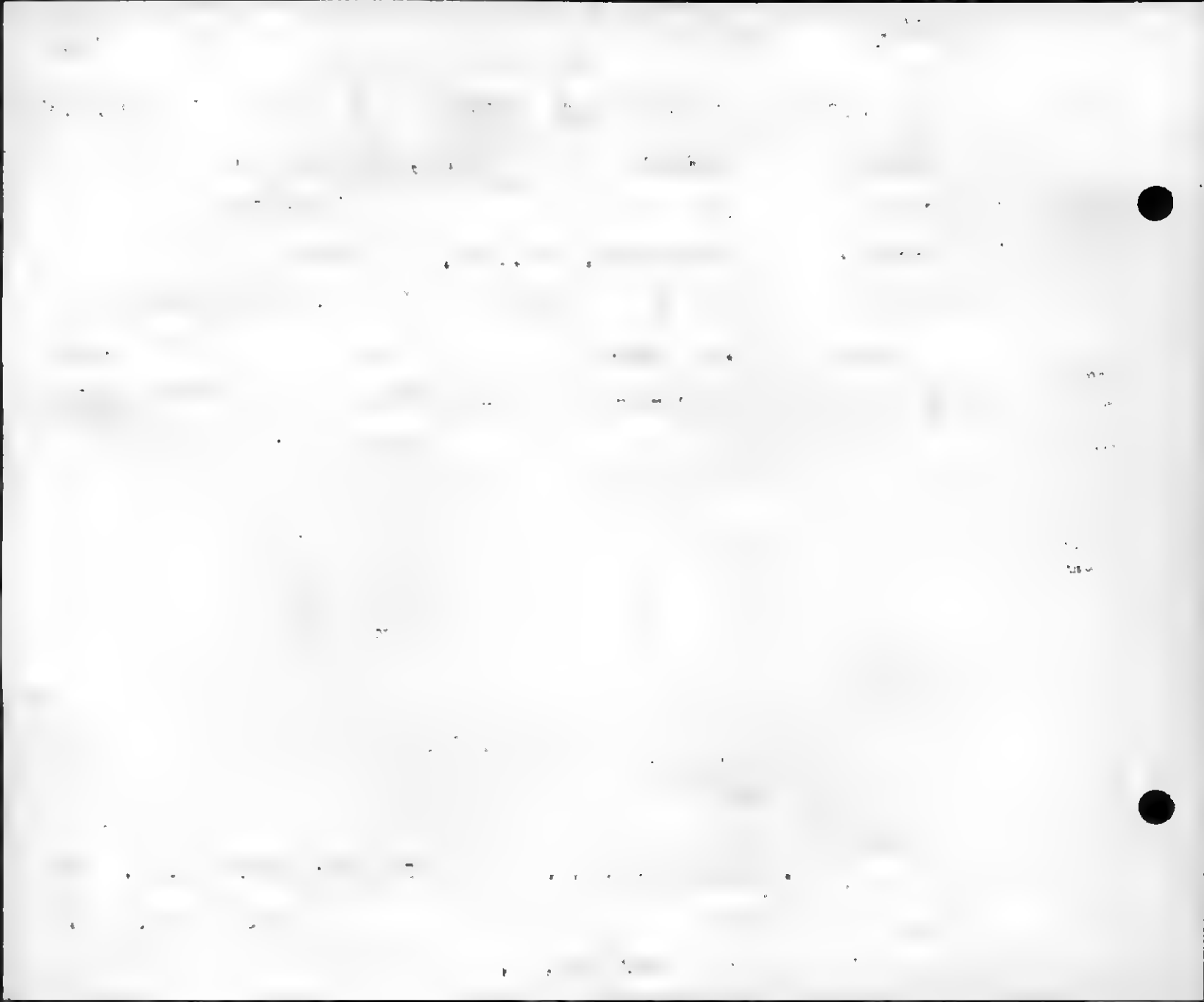


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

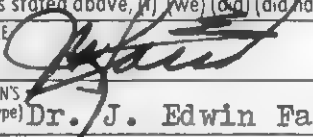

08401										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH										136														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
SUDIA JACKSON GREEN GIBSON										JUNE 6 1968					7:15 p m									
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN									
FEMALE			NEGROID			FEB. 6, 1877			91 YRS.															
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						Md									
MARYLAND			USA						DORCHESTER															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
CAMBRIDGE					CAMBRIDGE MD. HOSP., INC.					LABORER														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission, if any.)					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET AND NUMBER									
MARYLAND					DORCHESTER					CAMBRIDGE					806 HIGH STREET									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
THOMAS H. JACKSON					MARY JEW																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO					17 INFORMANT					Address									
NO					217-30-8653					WELDON GREEN					806 HIGH STREET 21613									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular renal																								
4120 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																								
(b) disease																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1967, to June 6, 1968, that (I) (we) last saw the deceased alive on June 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
J. EDWIN FASSETT, M.D.															June 7, 1968									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
J. EDWIN FASSETT, M.D.															623 HIGH STREET CAMBRIDGE, MD. 21613									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
BURIAL					6/9/68					WAUGH					CAMBRIDGE DOR. MD.									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE				
Ludwik C. Delair															JUN 12 1968					Charles Judge				
CAMBRIDGE, MD.																								

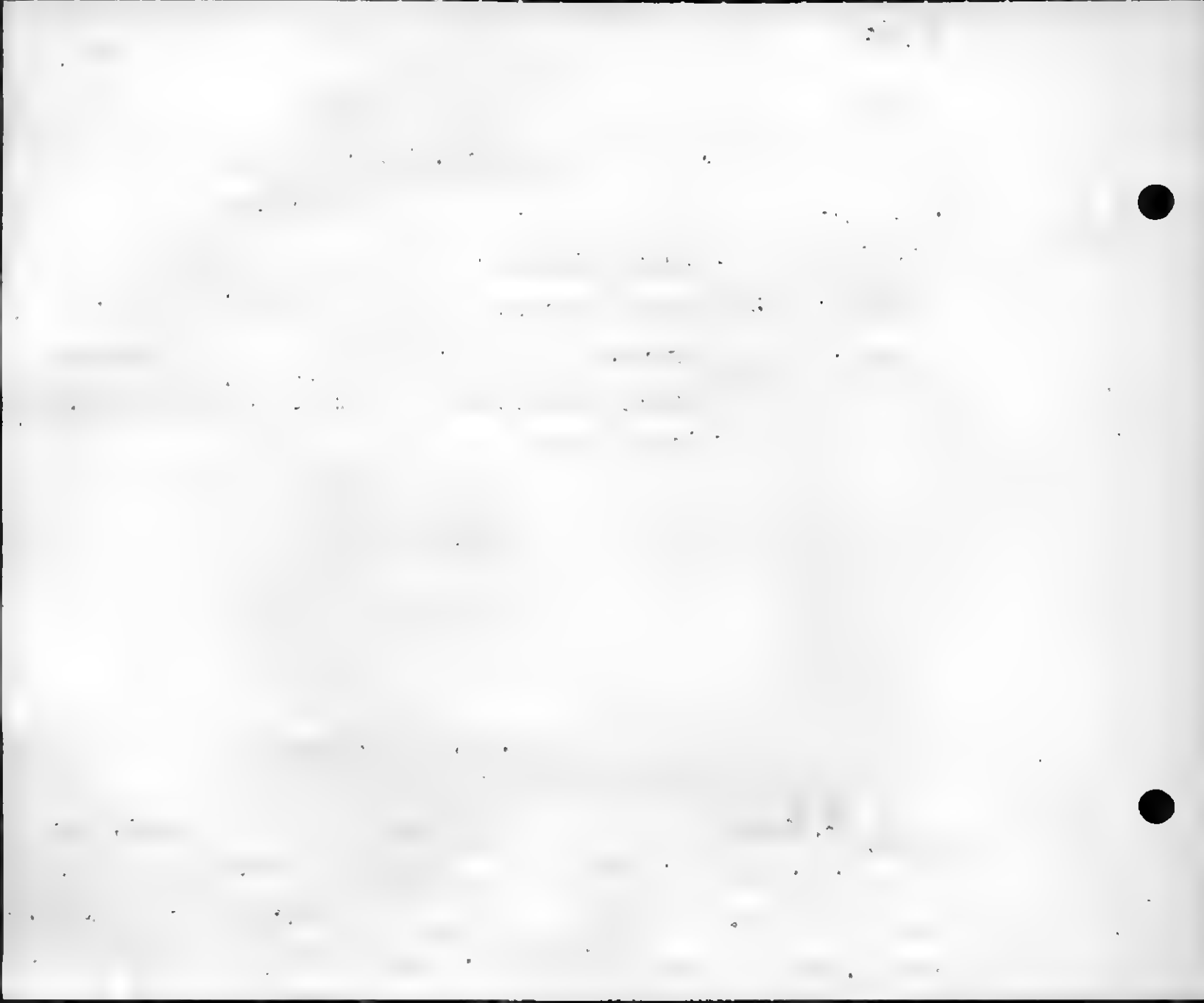


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VR A15 (4-)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) Mary			First Middle Last Green			2a. DATE OF DEATH Month June Day 25 Year 1968		2b. HOUR M 		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Apr. 12, 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Maryland		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1008 Phillips St.	
14. FATHER'S NAME First Middle Last General Freeman			15. MOTHER'S MAIDEN NAME First Middle Last Mary Skinner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 226 09 6859		17. INFORMANT Ernest Lee Watford Address 1008 Phillips St. Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pernicious Anemia 2010 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1964 , to June 25, 1968 , that (I) (we) last saw the deceased alive on June 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE 						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 28, 1968		
22d. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett						22e. ADDRESS High St, Cambridge, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/30/68		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester Md.				
24. FUNERAL DIRECTOR Barbara L. Dashiell ADDRESS 426 Dover				25a. REC'D BY REGISTRAR DATE JUL - 1 1968		25b. REGISTRAR'S SIGNATURE 				

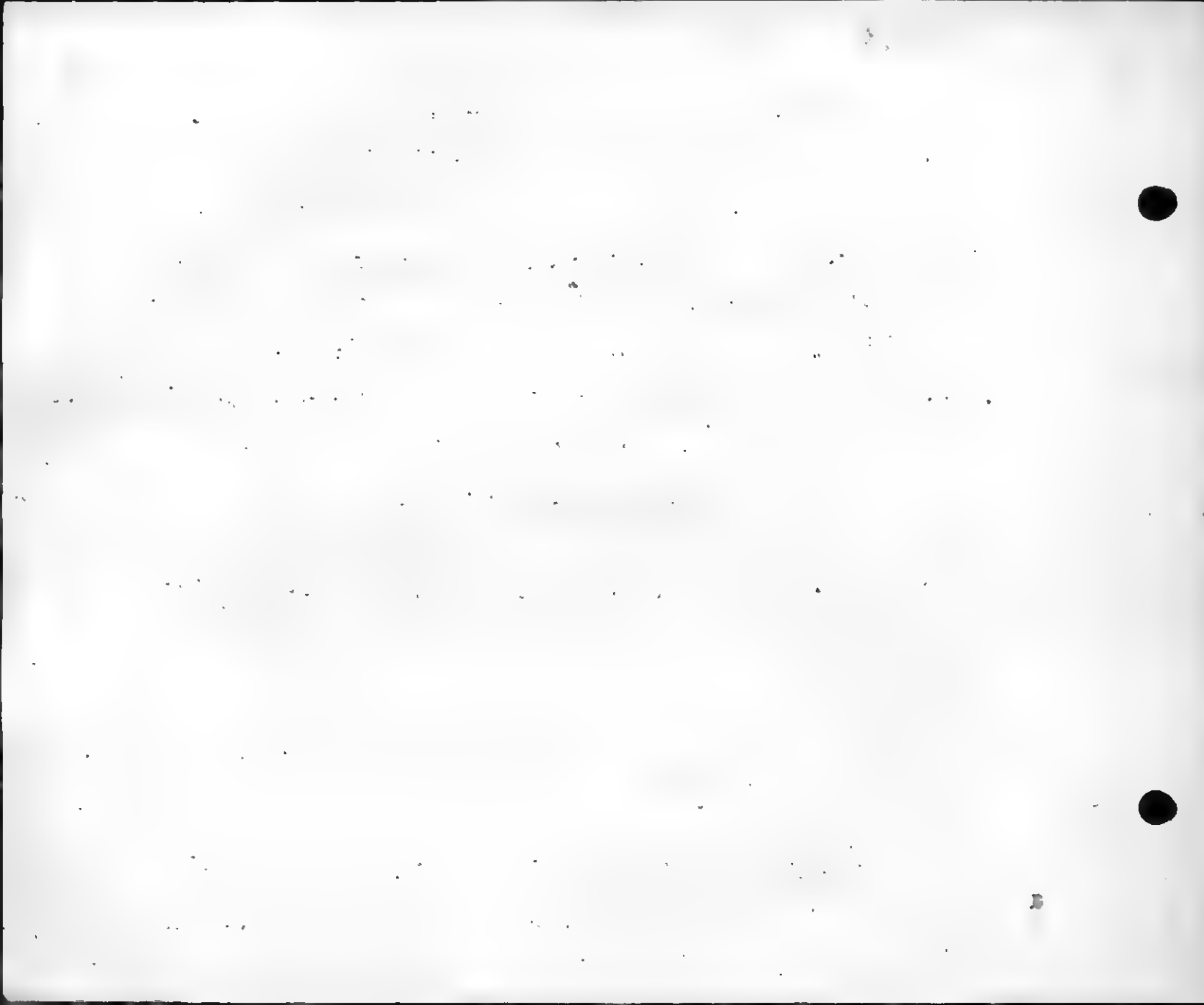


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VR 15-68
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Richard HAASS			2a. DATE OF DEATH Month Day Year 6 3 1968			2b. HOUR AM PM 2:45 AM					
3. SEX male		4. RACE White		5. DATE OF BIRTH 7-10-1887		6. AGE (In years lost birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester X Md					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Butcher-Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None			
14. FATHER'S NAME First Middle Last Michael HAASS			15. MOTHER'S MAIDEN NAME First Middle Last Not listed								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNKNOWN		16b. SOCIAL SECURITY NO. Not listed		17. INFORMANT Address Eastern Shore State Hosp (Med. Records)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS AT LEAST ONE MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; Chronic Bronchitis; Emphysema-											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from 5-20-1968 to 6-3-1968 , that (we) last saw the deceased alive on 6-3-1968 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.											
22b. SIGNATURE E. Lewis		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-3-68					
22d. PHYSICIAN'S NAME (Type) EDWARD LEWIS JR. MD		22e. ADDRESS ESS4, CAMBRIDGE, MD-									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-5-68		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro, Caroline Md.					
24. FUNERAL DIRECTOR John E. Boulais		ADDRESS Greensboro Md.		25a. REC'D BY REGISTRAR JUN 5 1968		25b. REGISTRAR'S SIGNATURE John E. Boulais					

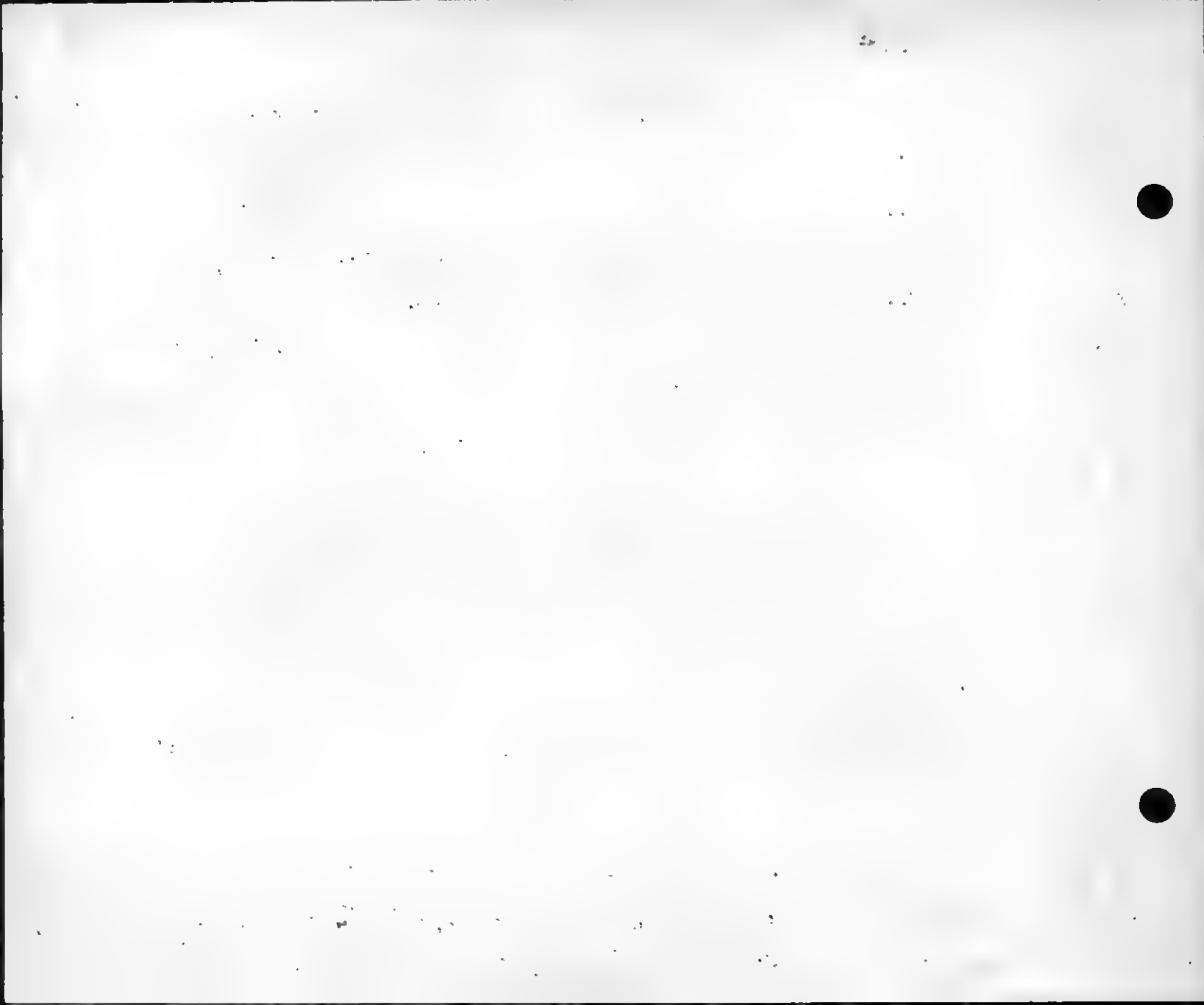


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
304A REV. 1-68

<div>02404</div> <div> <div>2</div> <div>1</div> </div> <div> <div>MD</div> <div>09</div> </div>									
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>PERCY</div> <div>Lloyd</div> <div>HENRY</div> </div>					<div>2a. DATE OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div>		<div>2b. HOUR</div> <div>Minute</div>		
<div>3. SEX</div> <div>MALE</div>		<div>4. RACE</div> <div>WHITE</div>		<div>5. DATE OF BIRTH</div> <div>5/23/90</div>		<div>6. AGE (In years last birthday)</div> <div>78 YRS</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>	
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>MD.</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.</div>		<div>8. MARRIED</div> <div>WIDOWED</div> <div>NEVER MARRIED</div> <div>DIVORCED</div>		<div>9. COUNTY OF DEATH</div> <div>DORCHESTER</div>			
<div>10. CITY OR TOWN OF DEATH</div> <div>RURAL CAMBRIDGE</div>		<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>EAST NEW MARKET SHORE STATE HOSP.</div>			<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Retired Carpenter</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div>		
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>STATE</div>		<div>13b. COUNTY</div> <div>DOR.</div>		<div>13c. CITY OR TOWN</div> <div>EAST NEW MARKET</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div>		<div>13e. STREET AND NUMBER</div>	
<div>14. FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div>				<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div>					
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</div> <div>Yes, no, or unknown</div> <div>NO</div>				<div>16b. SOCIAL SECURITY NO</div> <div>212-16-7497A</div>		<div>17. INFORMANT</div> <div>HOSPITAL RECORDS</div>			
<div>18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>485 X</div> <div>Blondie pneumonia</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div>									<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>
<div>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>4212</div>									
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>			<div>20a. AUTOPSY?</div> <div>YES</div> <div>NO</div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>		
<div>21a. ACCIDENT WAS UNDERLYING</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div> <div>(If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div>			<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>				
<div>21d. INJURY OCCURRED</div> <div>While</div> <div>Not while</div> <div>at work</div> <div>at work</div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)</div>			<div>21f. LOCATION</div> <div>Street or R.F.D. No.</div>		<div>City or Town</div>		<div>County</div>
<div>22a. I certify that (I) (this hospital) attended the deceased from 6/8, 1968, to 6/20, 1968, that (I) (we) last saw the deceased alive on 6/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>									
<div>22b. SIGNATURE</div> <div>F. M. Dominguez</div>					<div>DEGREE</div> <div>ATTENDING PHYS</div> <div>MED. DIRECTOR</div> <div>STAFF PHYS.</div>		<div>22c. DATE SIGNED</div> <div>6/20/68</div>		
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>FELIPE M. DOMINGUEZ, M.D.</div>					<div>22e. ADDRESS</div> <div>E.S.S. HOSPITAL, CAMBRIDGE, MD.</div>				
<div>23a. BURIAL CREMATION, REMOVAL (Specify)</div>		<div>23b. DATE</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div>		<div>23d. LOCATION (City or Town)</div>		<div>(County)</div>	
<div>24. FUNERAL DIRECTOR</div>		<div>ADDRESS</div>		<div>25a. REC'D BY REGISTRAR</div>		<div>25b. REGISTRAR'S SIGNATURE</div>			
Burial		6/23/68		East New Market		East New Market		Dorchester	
Dr. H. M. Dominguez		East New Market		East New Market		East New Market		Dorchester	
				JUN 26 1968		Charles Judge			

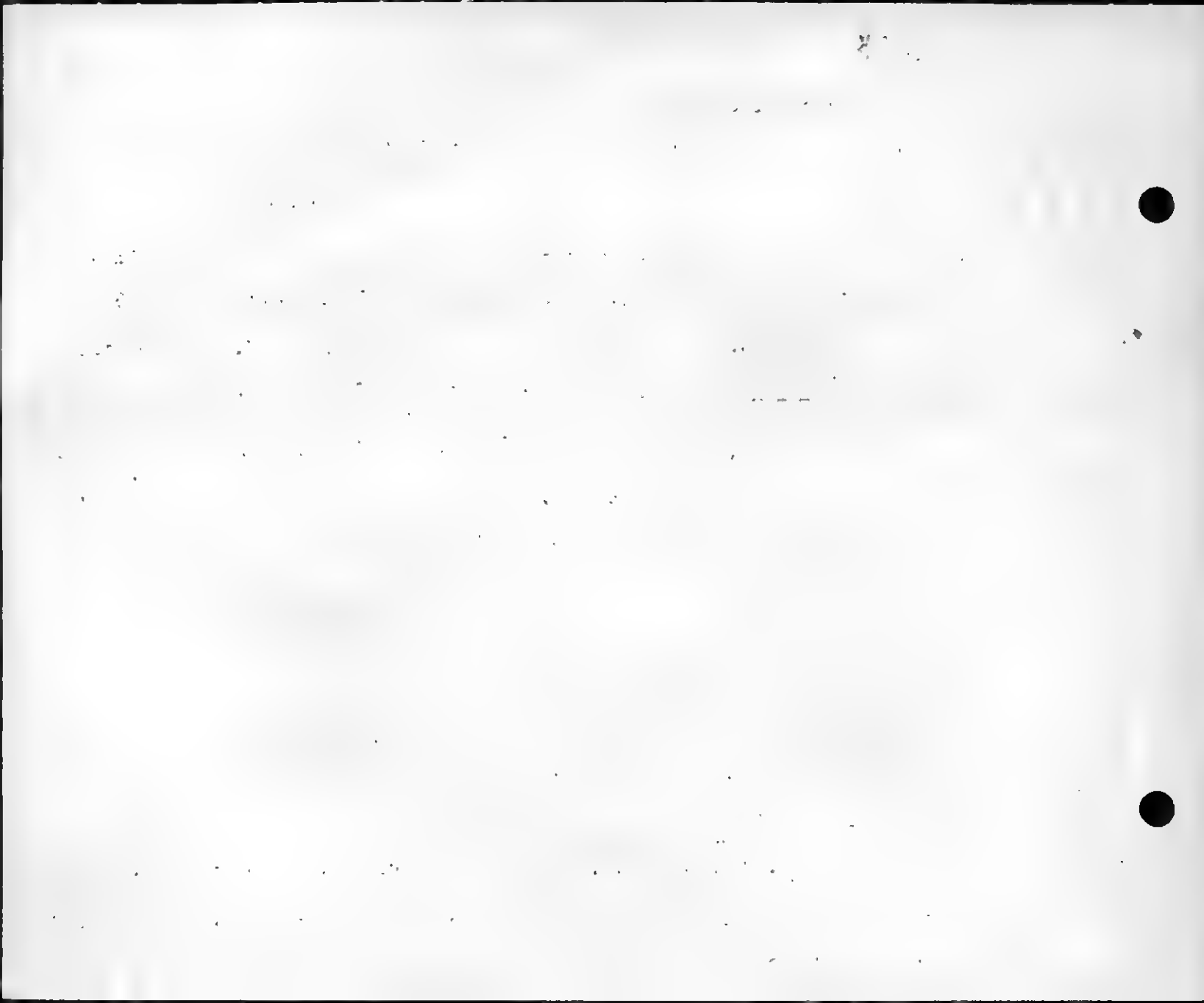


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VR A15
IM REV 46

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) GOLDSBOROUGH			First Z. Middle JAMES Last			2a. DATE OF DEATH Month June Day 30 Year 1968		2b. HOUR M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH December 15, 1899		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS 68 DAYS 68 HOURS 68 MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.			
10. CITY OR TOWN OF DEATH Near Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Town Point, RFD #3		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Dirt			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Town Point, RFD #3	
14. FATHER'S NAME First Joseph Middle H. Last James			15. MOTHER'S MAIDEN NAME First Clara Middle M. Last Lankford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) - - -		16b. SOCIAL SECURITY NO. unk		17. INFORMANT Address LeCompte Funeral Service records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constitution heart failure + H. pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) It									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 29, 1968 , to June 30, 1968 , that (I) (we) last saw the deceased alive on June 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James U. Thompson		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/2/68			
22d. PHYSICIAN'S NAME (Type) James U. Thompson, M.D.		22e. ADDRESS 602 Locust St., Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 2, 1968		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City or Town) (County) (State) East New Market, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUL - 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) DAVID ROBERT RAY JUSTICE			2a. DATE OF DEATH Month June Day 19 Year 1968		2b. HOUR 11:17 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 19, 1968		6. AGE (In years last birthday) YRS. 45	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 112 High Street	
14. FATHER'S NAME First Ray Middle Francis Last Justice		15. MOTHER'S MAIDEN NAME First Donna Middle Jean Last Meredith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT LeCompte Funeral Service records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STILLBORN PREMATURE 171X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 6-19, 1968 , to 6-19, 1968 , that (I) (we) last saw the deceased alive on 6-19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James F. McCarter			22c. DATE SIGNED 6-21-68		
22d. PHYSICIAN'S NAME (Type) JAMES F. McCARTER, M.D.			22e. ADDRESS P.O. 386 CAMBRIDGE, MD. 21613		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE June 20 1968	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland			25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

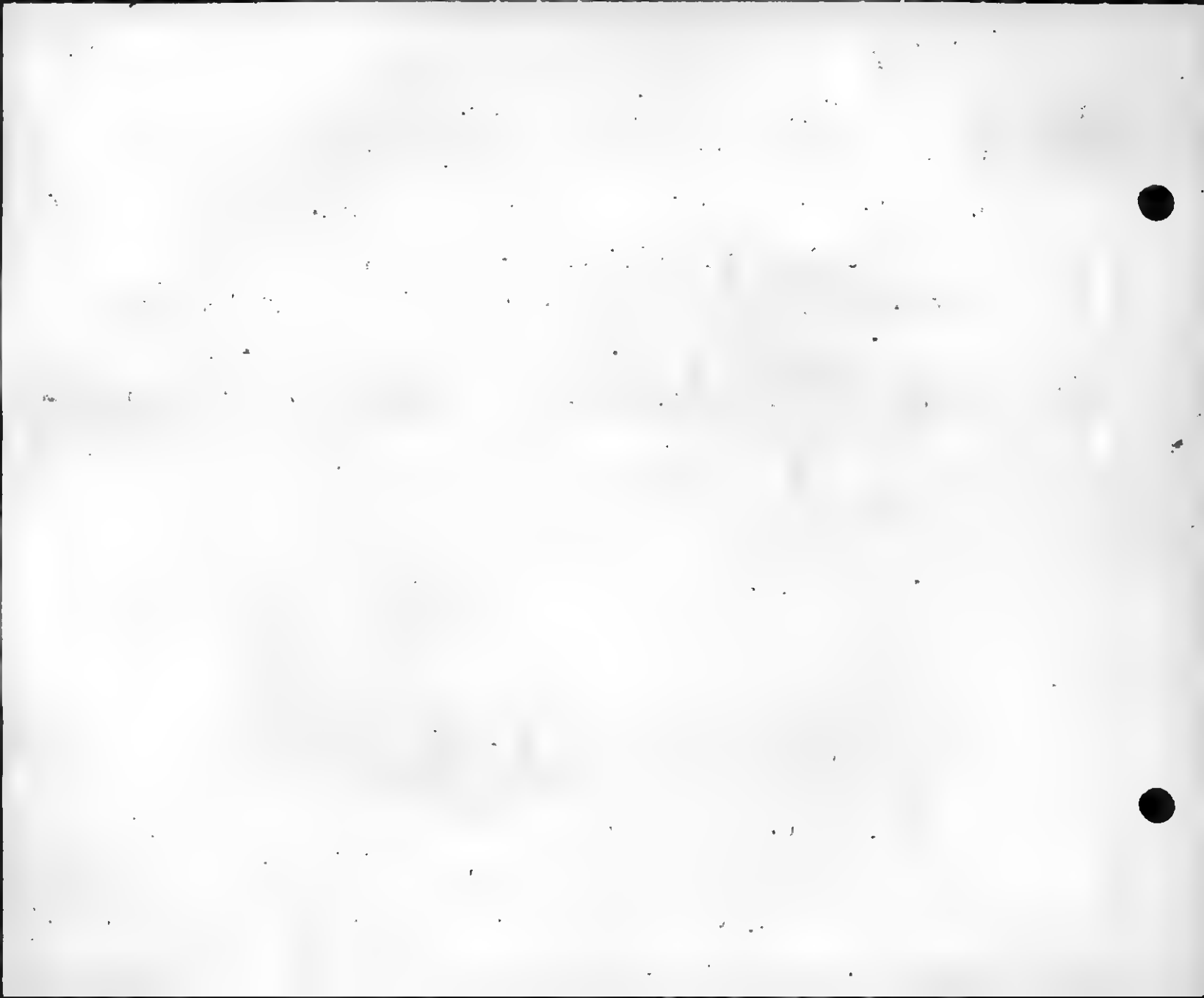
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VR A15
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR	
Alice R. Leishear					6 27 68			4:45AM	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	white		8-10-71		96 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A				Dorchester X Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cambridge (Rural)		Eastern Shore State Hosp		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)		13b. CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Dorchester		Hue/lock		S. MAIN Street			
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Thomas Colein		Elexina Colein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
UNKNOWN		NOT LISTED		Eastern Shore State Hosp (Medical Records)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia								10 Hours	
486X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. 4925									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
athero Sclerotic Heart Disease, Rheumatoid Arthritis, Hiatal Hernia									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from 4-8-68, 19, to 6-27-68, 19, that (I) (we) last saw the deceased alive on 6-26-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED							
Stephen H. Kaufman MD		6-27-68							
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Stephen H Kaufman		1604 N Calvert St Balto Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 1, 1968		Loudon Park		Frederick Ave. Balto. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard		4107 Wilkens Ave. 21229		JUL - 1 1968		J Charles Judge			

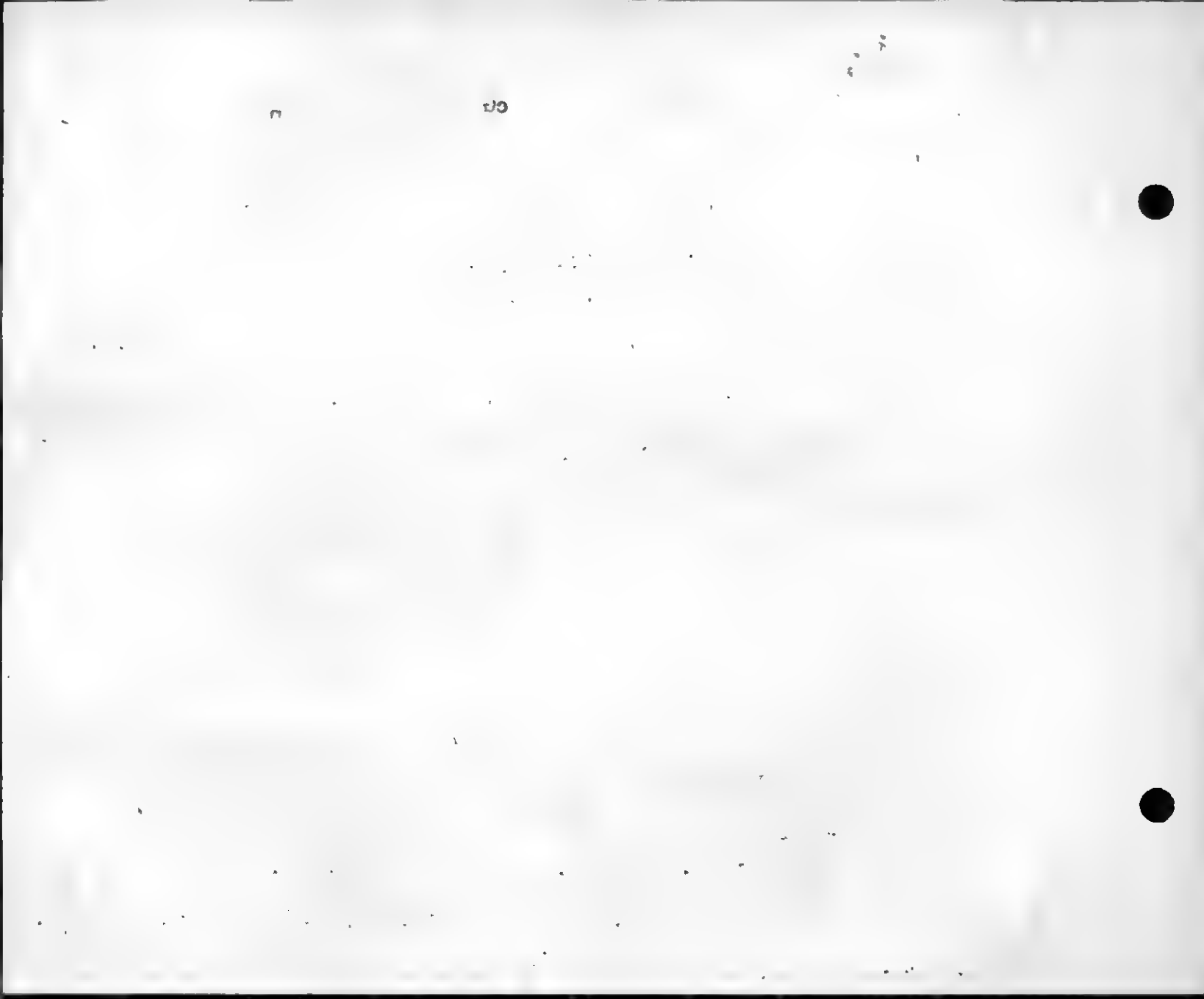


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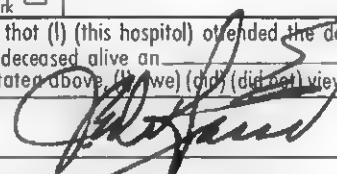
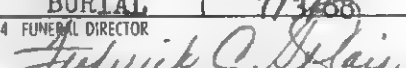

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 6, 1968	23c. NAME OF CEMETERY OR CREMATORY E. New Market Cemetery	23d. LOCATION (City or Town) E. New Market	(County) Dor.	(State) Md.
24. FUNERAL DIRECTOR Kenneth L. Thomas	ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1968	25b. REGISTRAR'S SIGNATURE James J. [Signature]	

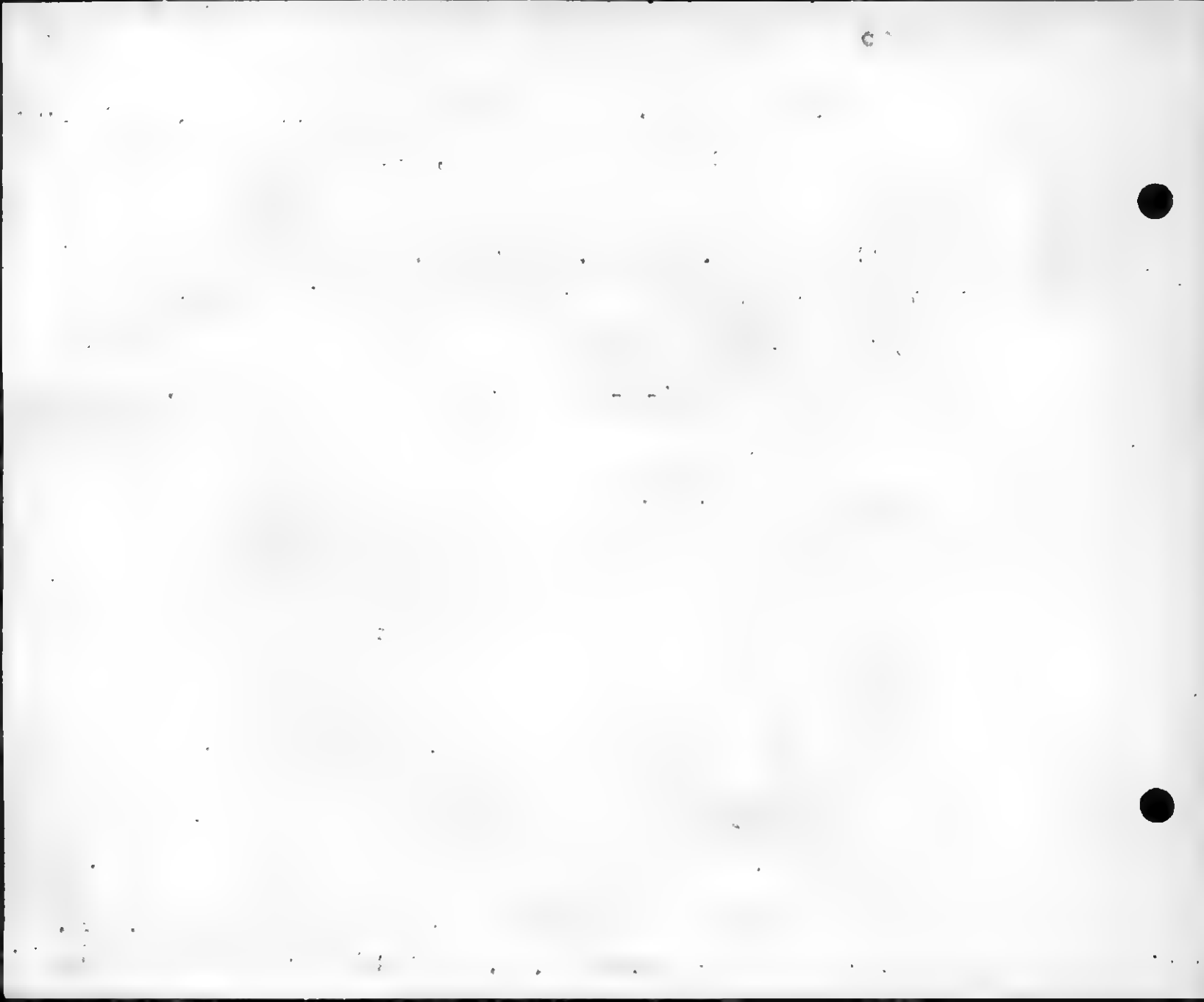
1. DECEASED NAME (Type or print)		First Elsie		Middle Pauline		Last McGrath		2a. DATE OF DEATH Month June Day 4 Year 1968		2b. HOUR 3 A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Sept. 26, 1901		6. AGE (In years last birthday) 66 YRS		IF UNDER YEAR MONTHS 66 DAYS 66		IF UNDER 24 HRS. HOURS 66 MIN. 66	
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Church Creek		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
14. FATHER'S NAME First Gustav Middle Kurth Last Kurth				15. MOTHER'S MAIDEN NAME First Fredericka Middle Talman Last Talman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO		17. INFORMANT Address Mr. William B. McGrath Church Creek, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cox											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 5/19/68 , 19____, to 6/4/68 , 19____, that (I) was lost saw the deceased alive on 6/3/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Mace Jr.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/4/68					
22d. PHYSICIAN'S NAME (Type) John Mace Jr.		M.D.		22e. ADDRESS Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 6, 1968		23c. NAME OF CEMETERY OR CREMATORY E. New Market Cemetery		23d. LOCATION (City or Town) (County) (State) E. New Market Dor. Md.					
24. FUNERAL DIRECTOR Benjamin L. Thomas Jr.		ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE [Signature]					



Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 00009 MARYLAND STATE DEPARTMENT OF HEALTH 214 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>									
1. DECEASED NAME (Type or print) GEORGE W. NICHOLS				2a. DATE OF DEATH Month JUNE Day 27 Year 1968				2b. HOUR 11:15	
3 SEX MALE		4. RACE NEGROID		5 DATE OF BIRTH MAY 5, 1899		6 AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOPITAL, INC.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) - STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1005 CAMELIA STREET	
14. FATHER'S NAME First Middle Last JAMES OLIVER NICHOLS				15. MOTHER'S MAIDEN NAME First Middle Last MARY CORNISH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 717-07-3699		17. INFORMANT Address LOLITA CLARK 706 LINCOLN TER. 21613					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia 4310 DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. - Hypertensive cardiovascular renal DUE TO, OR AS A CONSEQUENCE OF (c) disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1968</u> to <u>June 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-3-68			
22d. PHYSICIAN'S NAME (Type) EDWIN PAB ETT, M.D.				22e. ADDRESS 623 HIGH ST., CAMBRIDGE, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/3/68		23c. NAME OF CEMETERY OR CREMATORY BETHEL		23d. LOCATION (City or Town) (County) (State) CAMBRIDGE DOR. MD.			
24 FUNERAL DIRECTOR 				ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DATE JUL - 9 1968		25b. REGISTRAR'S SIGNATURE 	



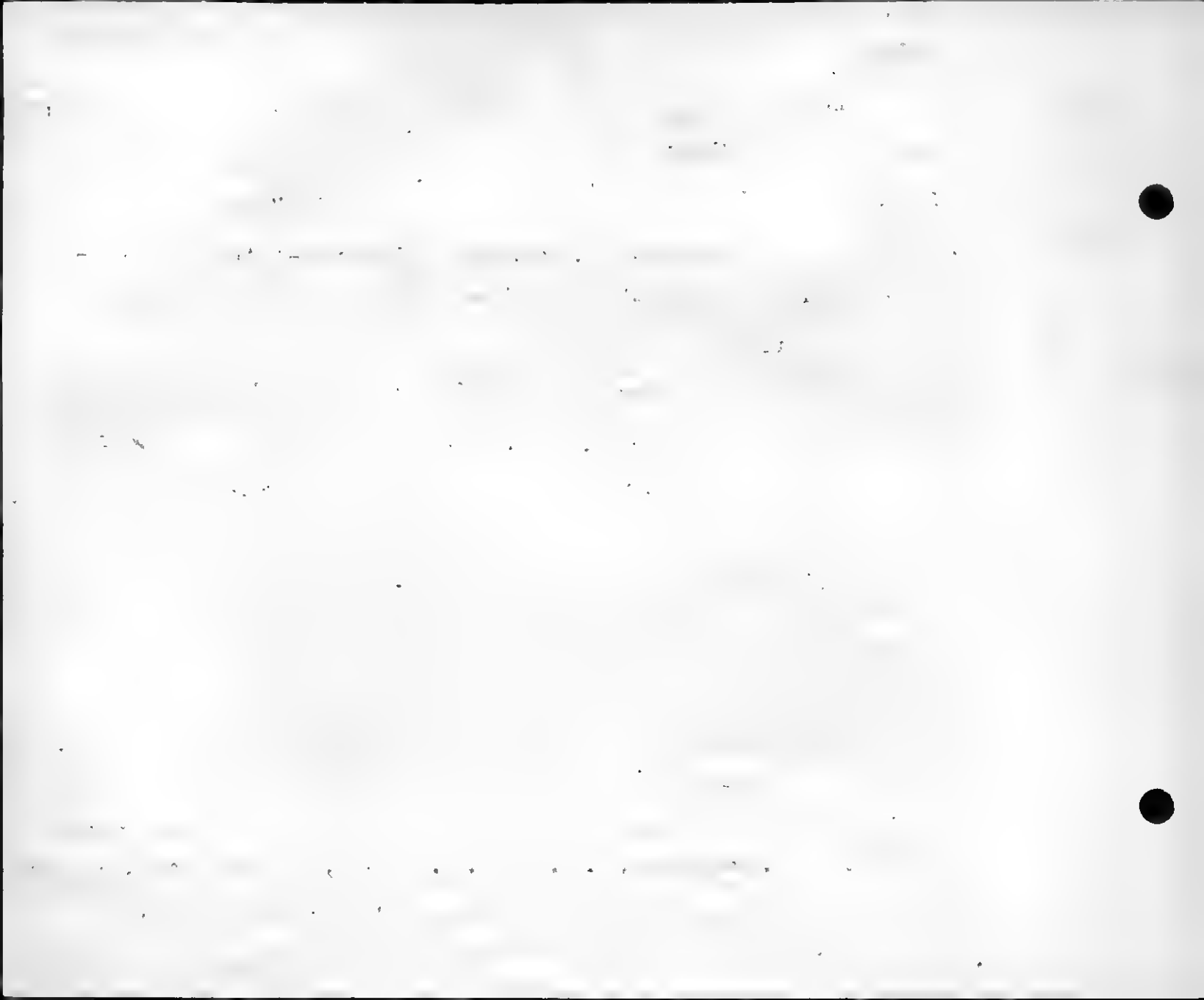
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 10
304 REV 1-68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First ALBERT Middle OSPERLUNG Last OSPERLUNG		2a. DATE OF DEATH Month June Day 8 Year 1968		2b. HOUR 8:10
3. SEX Male	4. RACE White	5. DATE OF BIRTH unk		6. AGE (in years last birthday) 84 YRS.
7a. BIRTHPLACE (State or foreign country) Finland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Caretaker-Retired	12b. KIND OF BUSINESS OR INDUSTRY - - -
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 301 Maryland Avenue
14. FATHER'S NAME First unk Middle unk Last unk		15. MOTHER'S MAIDEN NAME First unk Middle unk Last unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unk (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. unk	17. INFORMANT Address LeCompte Funeral Service records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4120 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 12 DAYS 12+ DAYS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GENERALIZED ARTERIOSCLEROSIS				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 68 , to 6-8 , 19 68 , that (I) (we) last saw the deceased alive on 6-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Donald R. McWilliams, MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 6-14-68	
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M. D.		22e. ADDRESS P. O. Box 248, East New Market, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jun 10 1968	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE JUN 18 1968	25b. REGISTRAR'S SIGNATURE Charles J. Jones	

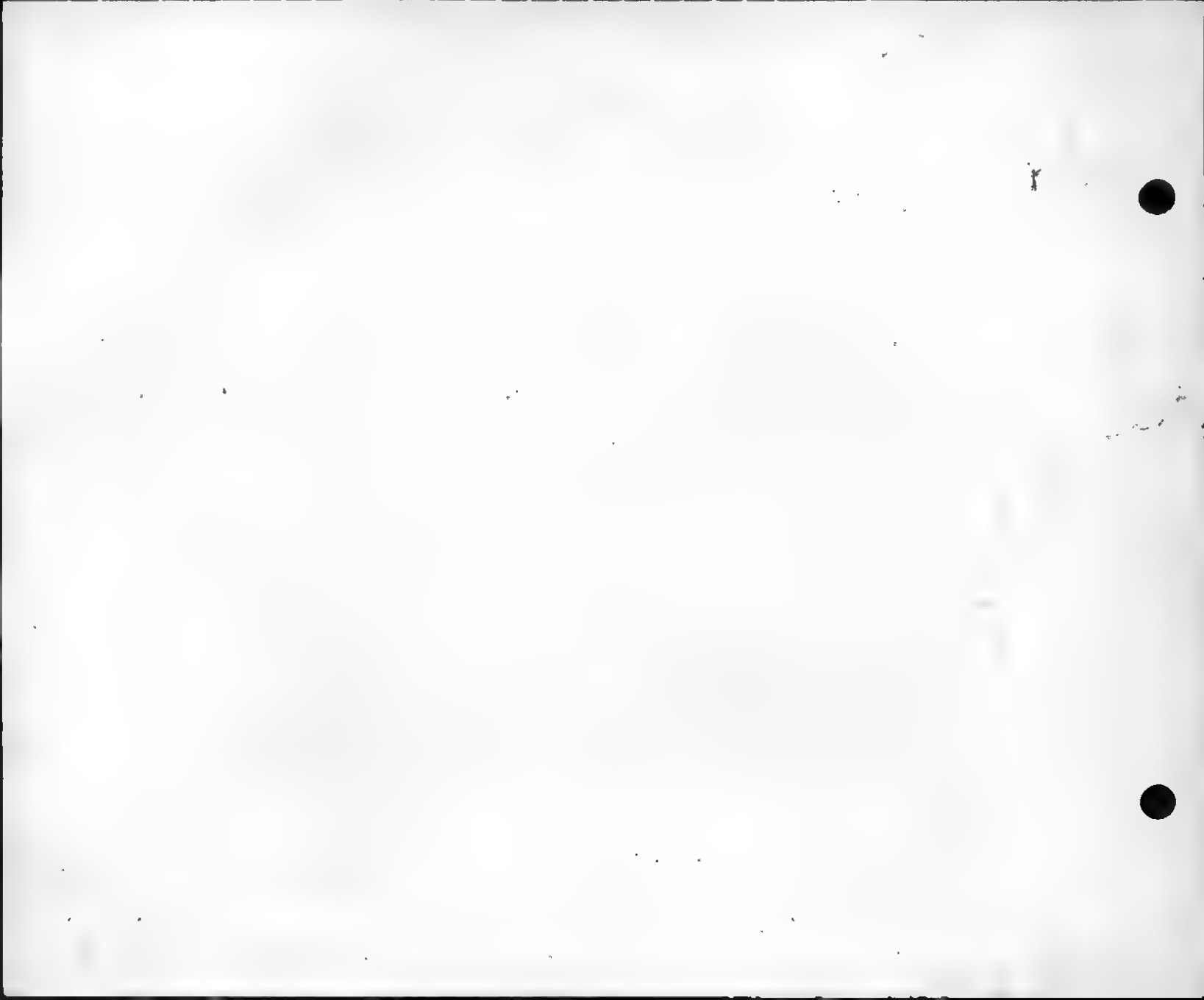


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in space 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Lula Todd Phillips						Month Day Year June 20 68		11AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	May 22, 1892	76 YRS			Month Day Year June 21 1968		M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Md.		U.S.				Dorchester Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Cambridge			213 Dorchester Ave.			Homemaker				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.			Dorchester		Toddville					
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last William Otto Hughes			First Middle Last Matilda Dayton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					Mr. Philip Todd Wingate Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									Instant	
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
420										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6/22/68				
John Mace Jr. M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cambridge, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		6/22/68		Zion Churchyard		Toddville Dor. Md.				
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Kenneth L. Thomas Jr.			Cambridge Md. 21613			DATE JUN 26 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

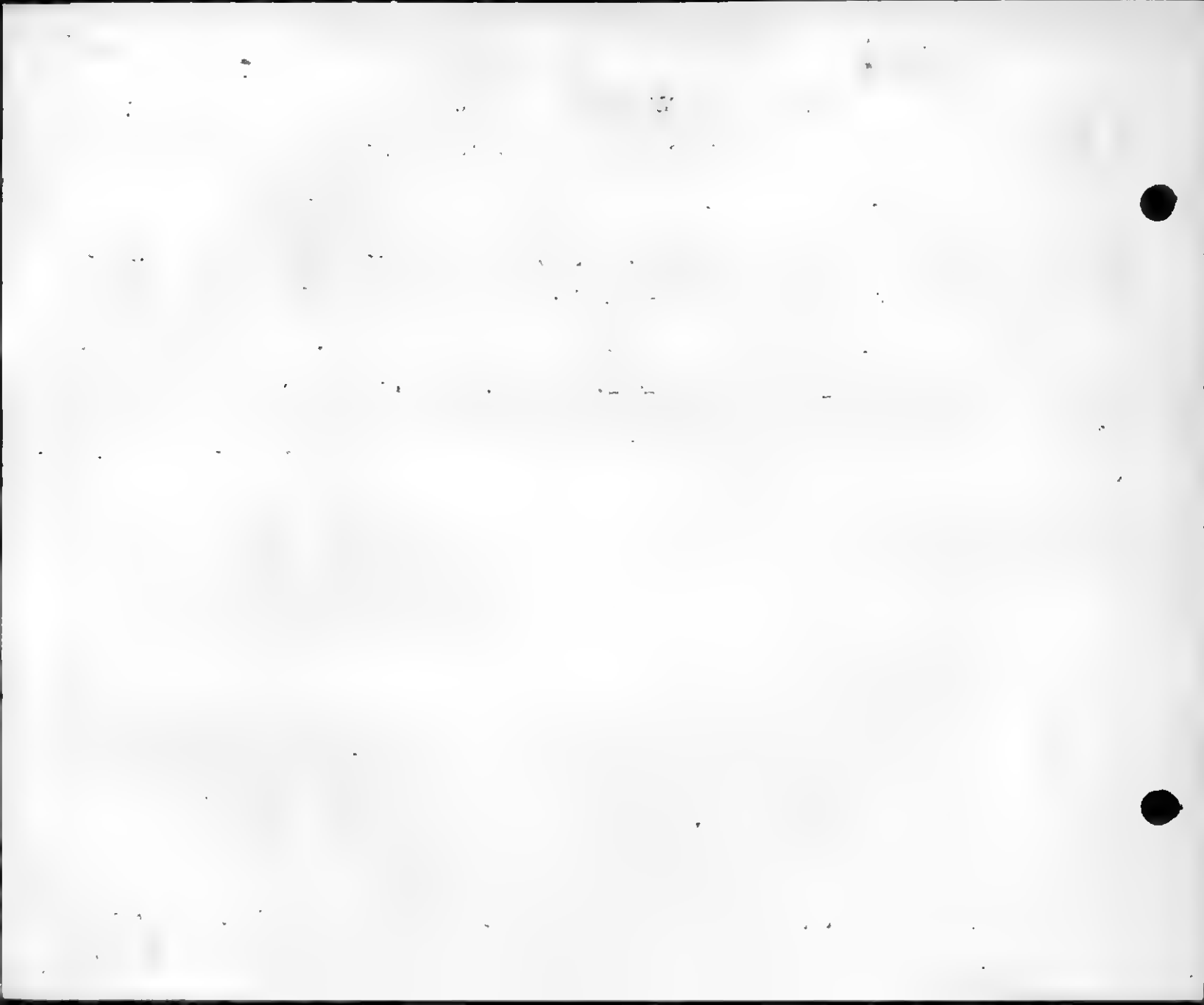
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First LOIS	Middle BRADLEY	Last PRICE	2a. DATE OF DEATH Month Day Year June 17, 1968		2b. HOUR 9:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 6, 1893		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Factory			
3a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 704 Travers Street	
14. FATHER'S NAME First Middle Last Jesse ? Bradley		15. MOTHER'S MAIDEN NAME First Middle Last Octavia ? ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No - - -		16b. SOCIAL SECURITY NO 214-07-7680		17. INFORMANT LeCompte Funeral Service records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast carcinoma, metastatic</u> 11411 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 11		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-10, 1968, to 6-17, 1968, that (I) (we) last saw the deceased alive on 6-17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard G. Bilodeau		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-18-68					
22d. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU		22e. ADDRESS CAMBRIDGE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. RECD BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

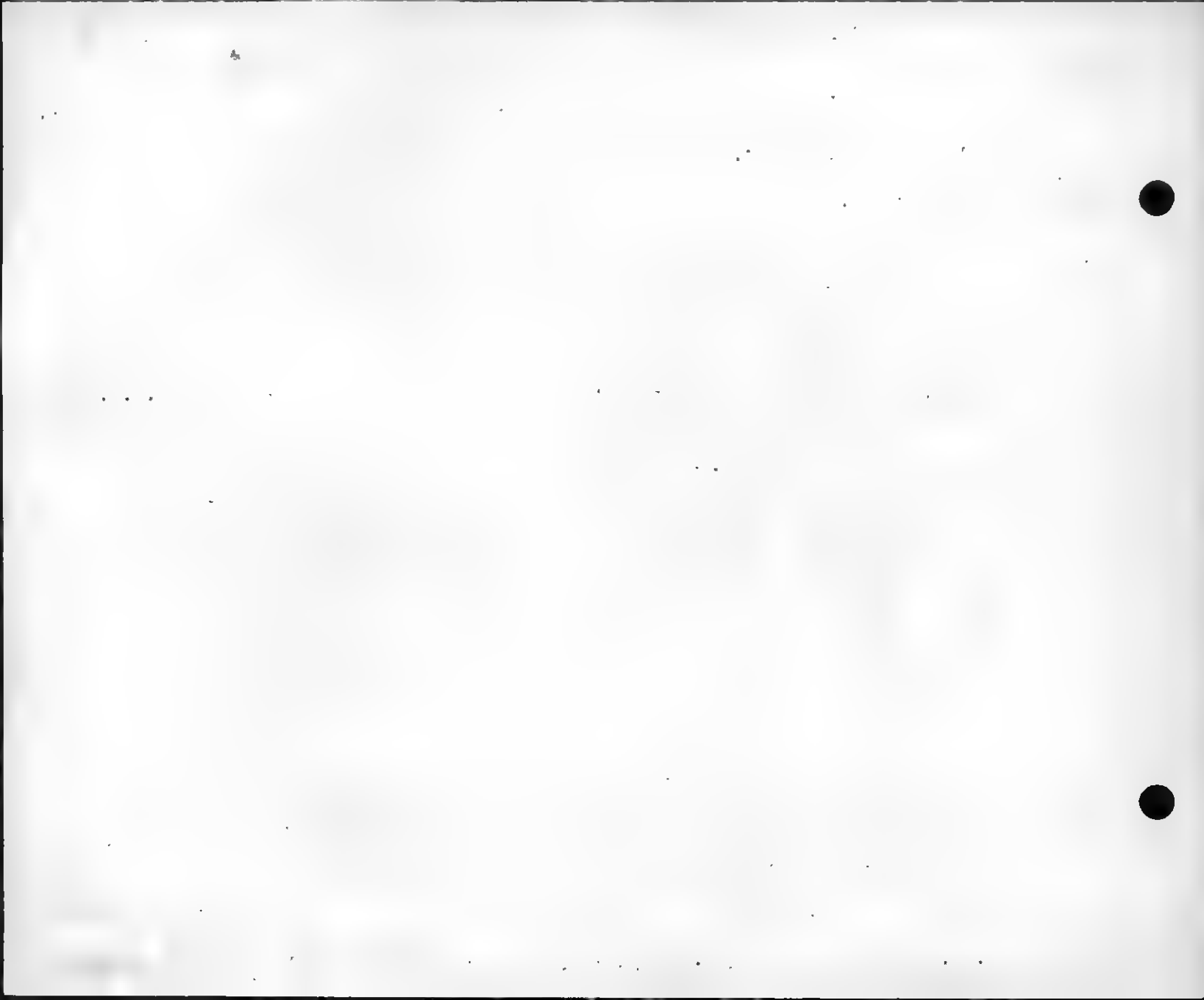


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. DECEASED NAME (Type or Print)			First PERRY			Middle RIGGINS			Last RIGGINS			2a. DATE KNOWN OF DEATH	Month June	Day 22	Year 68	2b. HOUR 8:30
3 SEX Male	4. RACE Negro	5. DATE OF BIRTH Oct. 25, 1924	6. AGE (in years last birthday) 43 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD	Month June	Day 22	Year 1968	2d. HOUR 4:45				
7a. BIRTHPLACE (State or foreign country) Norfolk, Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Dorchester							
10. CITY OR TOWN OF DEATH Hurlock			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harrison Ferry Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Day Laborer			12b. KIND OF BUSINESS OR INDUSTRY Canning Factory							
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Hurlock			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Harrison Ferry Road				
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME										
First Unknown						First Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes?			16b. SOCIAL SECURITY NO. 214-32-5291			17. INFORMANT Edna Wright, Hurlock, Maryland, R.F.D. #2										
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral bronchopneumonia																
DUE TO, OR AS A CONSEQUENCE OF (b) with abscess formation																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 40																
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE P. W. Rieckert						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 7-3-68				
EXAMINER'S NAME (Type) Peter V. Rieckert, E-New Market, Md.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										
						ADDRESS (Street, city, town or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 2, 1968			23c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery			23d. LOCATION (City or Town) (County) (State) Near Rhodesdale, Maryland							
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalburg, Maryland						25a. REC'D BY REGISTRAR JUL 10 1968						25b. REGISTRAR'S SIGNATURE Charles Judge				



MD 116
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First Middle Last <i>Lula Chatman Roberts</i>			2a. DATE OF DEATH Month Day Year <i>06 30 68</i>			2b. HOUR <i>8:25 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>08-15-93</i>		6. AGE (In years lost birthday) <i>74</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i> Md	
10. CITY OR TOWN OF DEATH <i>Rural-Cambridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>factory WORK</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Bivalve</i>		13d. INSIDE CITY, J.M. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>John T. Neath</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Sarah Elizabeth Whites</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-10-9809</i>		17. INFORMANT <i>Med. Records</i> Address <i>Eastern Shore State Hospital</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction of myocardium</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4109</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Felipe M. Dominguez MD</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/1/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>FELIPE M. DOMINGUEZ</i>		22e. ADDRESS <i>ESS 4 Cambridge, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/3/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prisons Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>53115644 Md</i>	
24. FUNERAL DIRECTOR <i>C G Moser, Brandy Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JUL - 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	



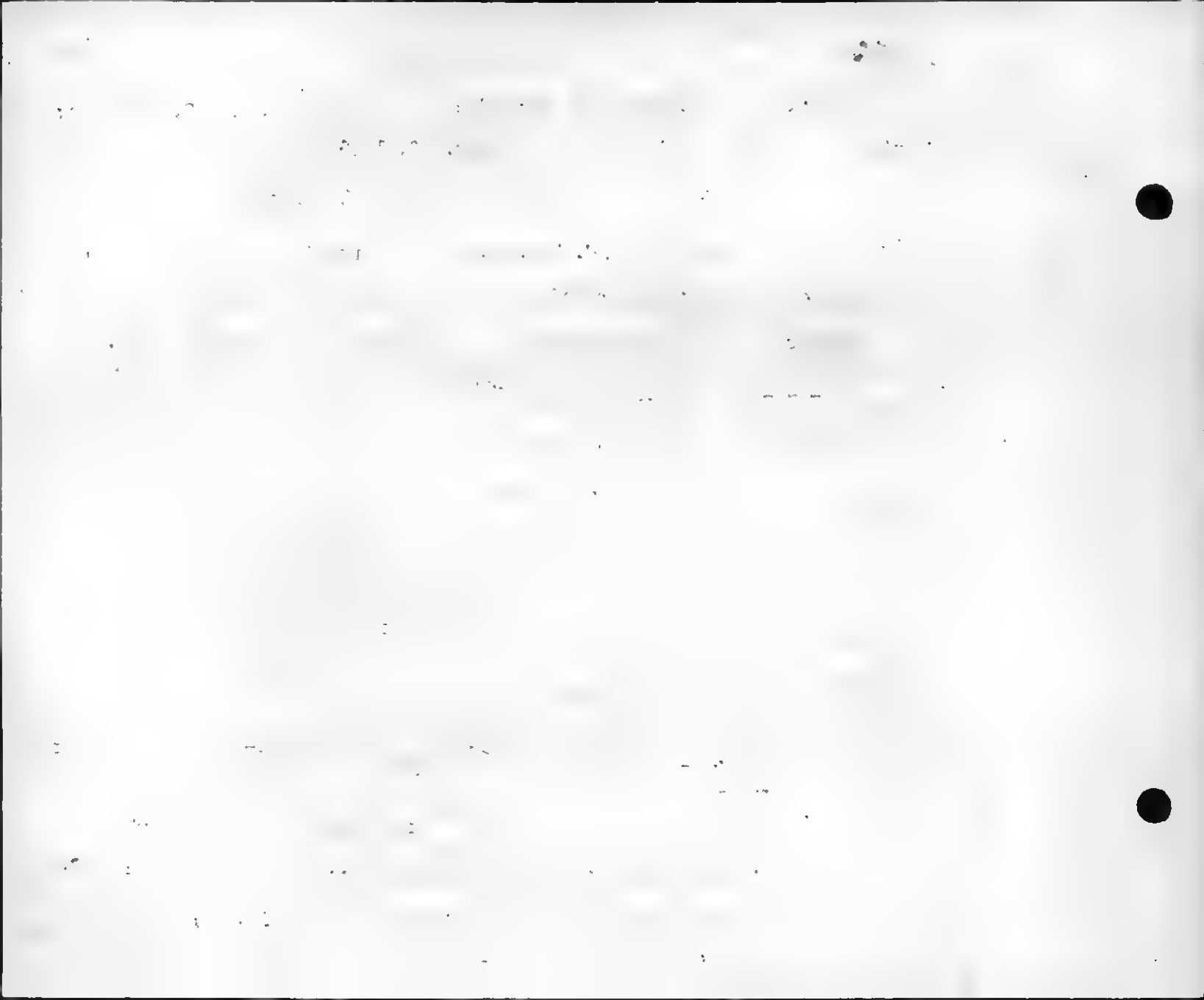
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VR 115
30M REV 1-68

MD 115
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First MARY Middle ELLEN Last ROBINSON			2a. DATE OF DEATH Month June Day 2, Year 1968		2b. HOUR 1:20AM
3 SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 23, 1909		6. AGE (In years last birthday) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester Md.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Toddville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14 FATHER'S NAME First Shriver Middle ? Last McGlaughlin	15. MOTHER'S MAIDEN NAME First Mary Middle Ellen Last Todd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO unk	17 INFORMANT LeCompte Funeral Service records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3318					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-15-68, 19, to 6-2-68, 19, that (I) (we) lost saw the deceased alive on 6-1-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Albert E. Bunker, M.D.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 6-3-68		
22d. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		22e. ADDRESS 200 Md. Ave., Cambridge, Maryland 21613			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jun 4, 1968	23c. NAME OF CEMETERY OR CREMATORY Zion Methodist Churchyard	23d. LOCATION (City or Town) (County) (State) Toddville, Maryland		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE JUN 7 1968	25b. REGISTRAR'S SIGNATURE William A. Jager		



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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08421

1 DECEASED-NAME (Type or print) First Middle Last Miranda Augusta Rumbley			2a DATE OF DEATH Month Day Year June 17 1968		2b HOUR 12:30 PM
3 SEX Female	4. RACE White	5. DATE OF BIRTH January 28, 1899		6 AGE (In years lost birthday) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Dorchester Md.		
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Dorchester	13c CITY OR TOWN Cambridge	13d INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 802 Glasgow St.
14. FATHER'S NAME First Middle Last Ernest. A. Gillis		15. MOTHER'S MAIDEN NAME First Middle Last Effie M. Wroten			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 211-07-9503		17. INFORMANT Address Mr. Calvin Rumbley Cambridge Md. 2161	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 451X <u>Hypertension</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 1968, to <u>6-17</u> , 1968, that (I) (we) last saw the deceased alive on <u>6-16</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>W. J. [Signature]</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c DATE SIGNED 6-17-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/19/68	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park		23d LOCATION (City or Town) (County) (State) Cambridge Dor. Md.
24. FUNERAL DIRECTOR <u>Keith R. [Signature]</u>		ADDRESS Cambridge Md. 21613		25a. RECD BY REGISTRAR DATE JUN 20 1968	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



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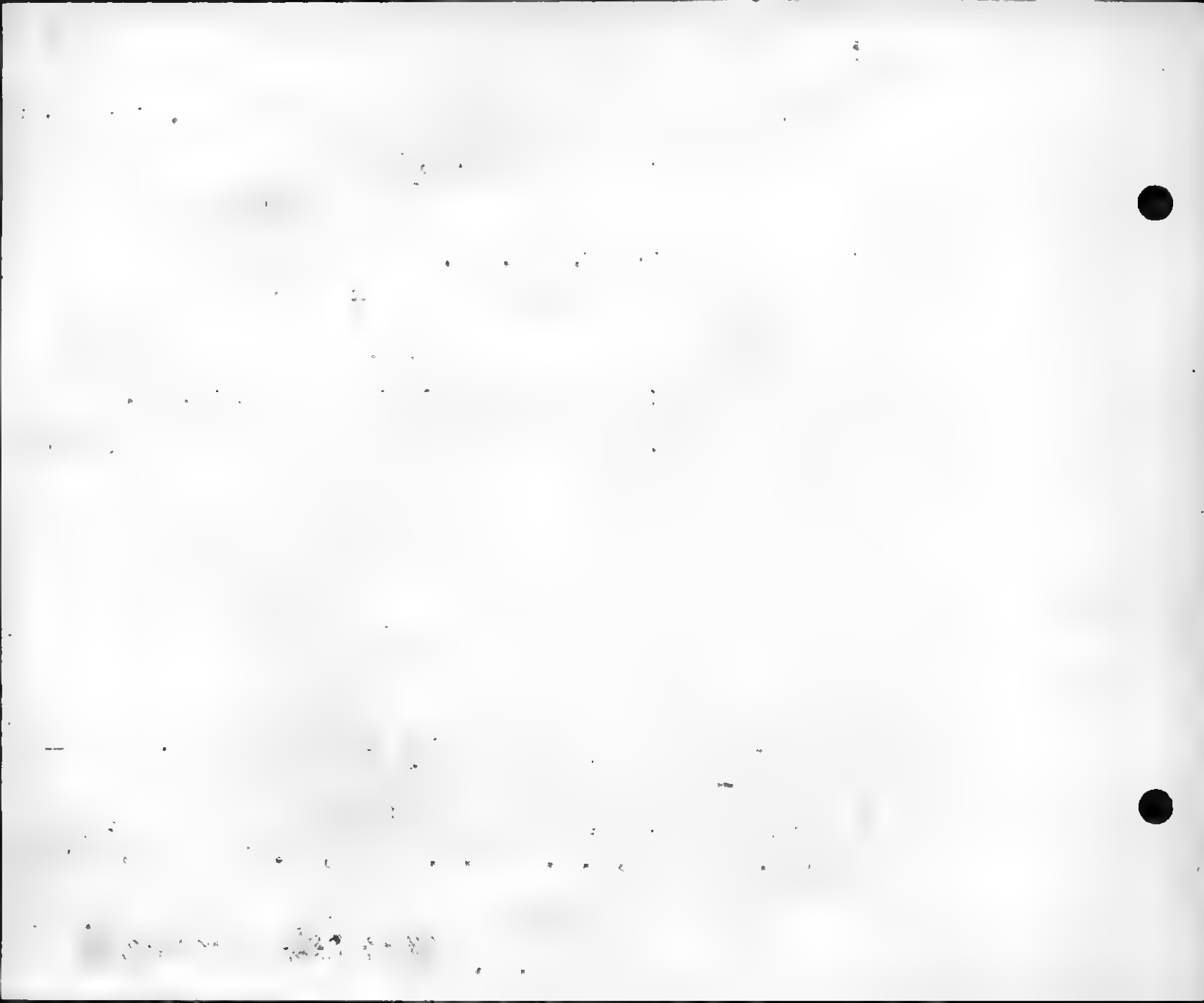
MD417

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LAWRENCE			First Middle Last			2a. DATE OF DEATH Month Day Year JUNE 24, 1968			2b. HOUR 11:43		
3 SEX MALE			4. RACE NEGROID			5. DATE OF BIRTH MARCH 5, 1968			6. AGE (In years last birthday) YRS. 3 MONTHS 3 DAYS 3		
7a. BIRTHPLACE (State or foreign country) FLORIDA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH DORCHESTER Md.		
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOSP. INC.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN RHODESDALE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last LERIA SAUNDERS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. NONE		
17. INFORMANT LERIA SAUNDERS			Address PALATKA, FLA.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) 400X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ DAYS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Y											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-22, 1968 , to 6-24, 1968 , that (I) (we) lost saw the deceased alive on 6-23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald R. McWilliams, MD			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6-26-68					
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M. D.			22e. ADDRESS P. O. Box 248, East New Market, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE 7/1/68			23c. NAME OF CEMETERY OR CREMATORY EVERGREEN			23d. LOCATION (City or Town) (County) (State) PALATKA PUTMAN FLA.		
24. FUNERAL DIRECTOR Fredrick C. St. Clair			ADDRESS CAMBRIDGE, MD.			25a. REC'D BY REGISTRAR JUL-9-1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

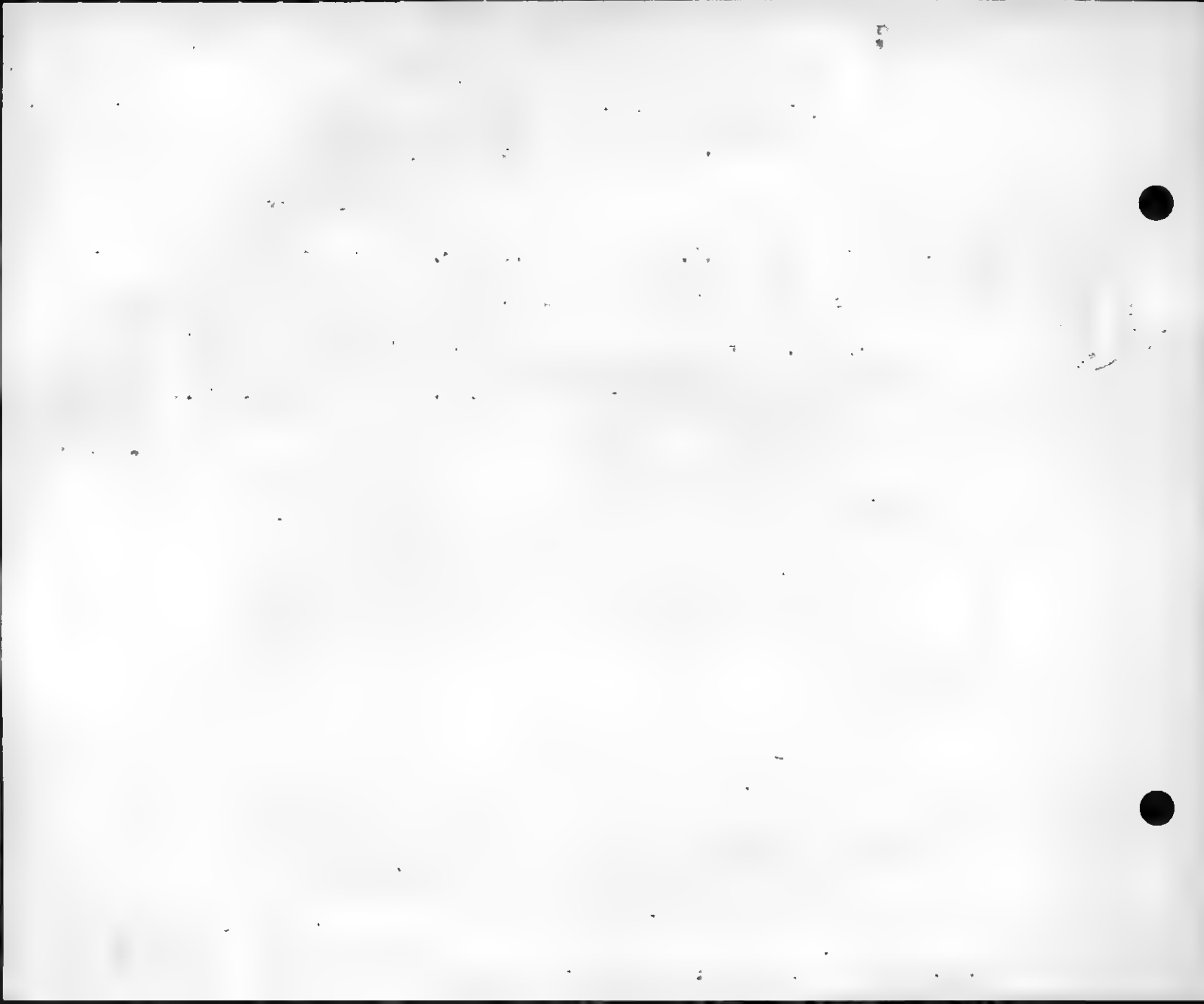


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VR A15 M
30M REV 1-68

<div>00418</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>00423</div>																							
1. DECEASED-NAME (Type or print)			First MYRTLE			Middle GRAVENOR			Last SHORT			2a. DATE OF DEATH Month June			Day 4			Year 1968			2b. HOUR 10 P M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH August 5, 1890			6. AGE (In years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN								
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Dorchester Md.														
10. CITY OR TOWN OF DEATH Galestown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) (P.O. Seaford, Del., RFD #3)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework			12b. KIND OF BUSINESS OR INDUSTRY Home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Dorchester			13c. CITY OR TOWN Galestown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER											
14. FATHER'S NAME First William W. Brinsfield						15. MOTHER'S MAIDEN NAME First Mary Wheatley						Address											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 218-10-9638			17. INFORMANT Lester K. Short, Seaford, Del., RFD #3						Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> C11.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cholelithiasis</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>June 4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>H.S. Kuhlman</u>						22c. DATE SIGNED 9/5/68																	
22d. PHYSICIAN'S NAME (Type) <u>H.S. Kuhlman</u>						22e. ADDRESS <u>Seaford, Del.</u>																	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE June 7, 1968			23c. NAME OF CEMETERY OR CREMATORY Galestown Cemetery			23d. LOCATION (City or Town) (County) (State) Galestown, Maryland														
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalville, Maryland</u>						25a. REC'D BY REGISTRAR DATE JUN 21 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

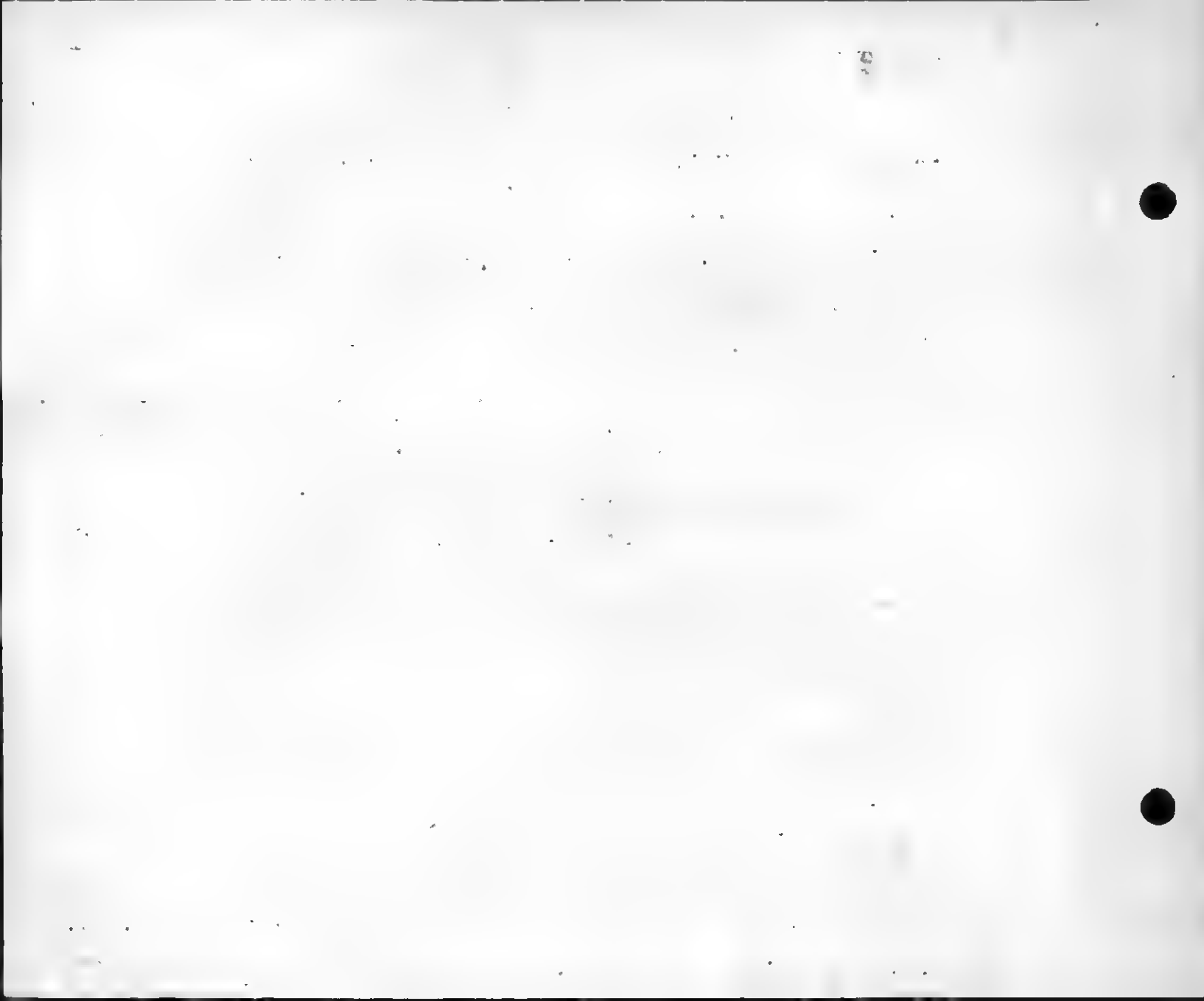
VR A15 (4)
30M REV 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Mary Lewis Byrn Simmons			2a. DATE OF DEATH Month Day Year June 18 1968		2b. HOUR 3:45 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 11, 1896		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester Md.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY - HITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route #2	
14. FATHER'S NAME First Middle Last Samuel L. Byrn		15. MOTHER'S MAIDEN NAME First Middle Last Imogene Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Wilbur N. Baumann Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> 5/20/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrotic Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pyelonephritis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos 3 yrs 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 6, 1967, to June 18, 1968, that (I) (we) lost saw the deceased alive on 6-18-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. Baumann</u>				22c. DATE SIGNED 6-21-68	
22d. PHYSICIAN'S NAME (Type) Kenneth R. Hennes				22e. ADDRESS Cambridge Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/20/68		23c. NAME OF CEMETERY OR CREMATORY Christ Churchyard	
23d. LOCATION (City or Town) (County) (State) Cambridge Dor. Md.					
24a. FUNERAL DIRECTOR Kenneth R. Hennes		24b. ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR DATE JUN 26 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

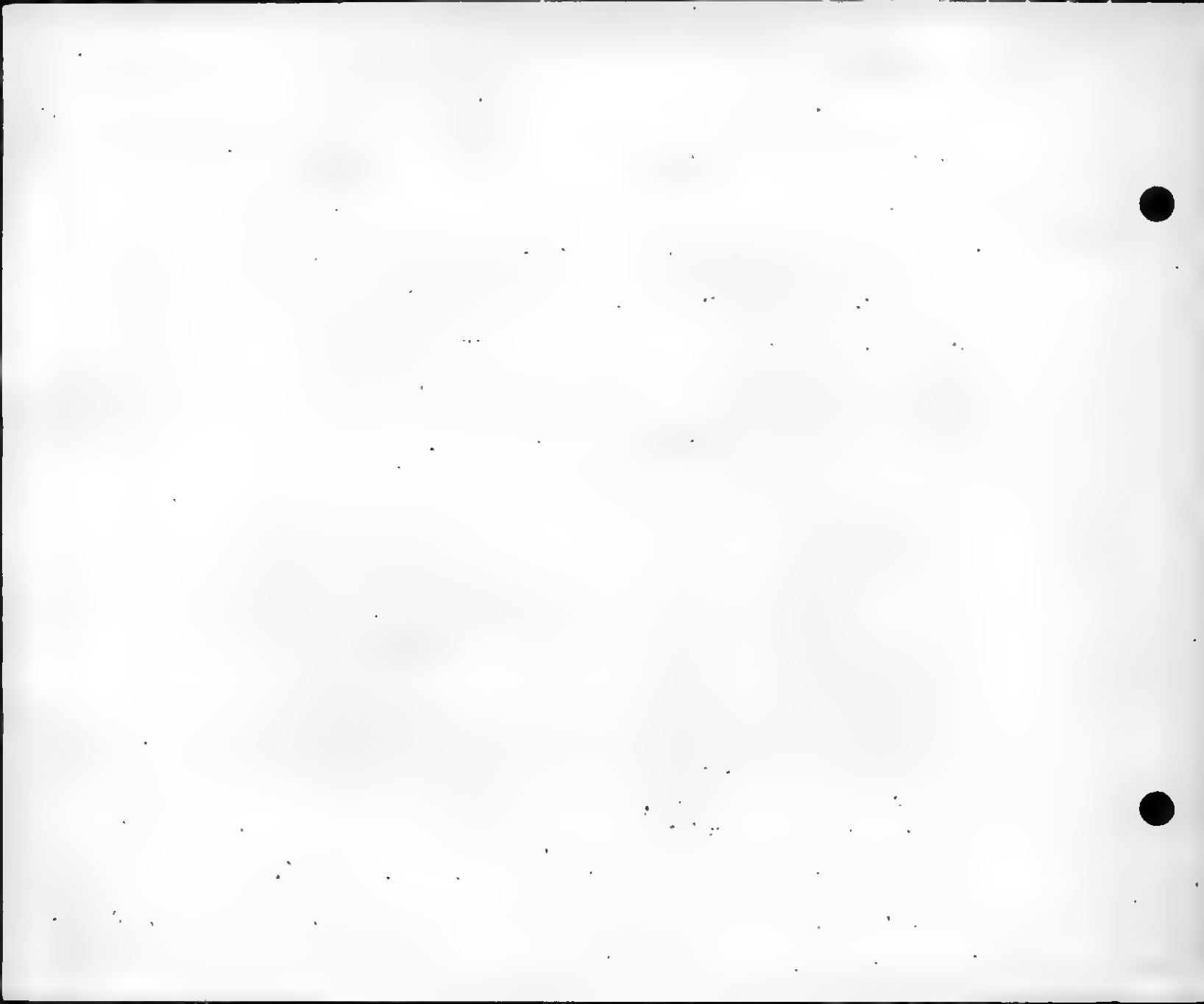


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY		First Middle Last		2a. DATE OF DEATH JUNE 3 Month 1968 Day Year		2b. HOUR 10:30M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/8/96		6. AGE (In years last birthday) 72 YRS	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DOR.	
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY QUEEN ANNE'S		13c. CITY OR TOWN CHURCH HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last GEORGE A. SKINNER		15. MOTHER'S MAIDEN NAME First Middle Last SUSIE MERCHANT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JULY 2, 1935 , to JUNE 3, 1968 , that (I) (we) lost saw the deceased alive on JUNE 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Pete W. Rieckert</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/3/68	
22d. PHYSICIAN'S NAME (Type) Pete W. Rieckert				22e. ADDRESS E-New Market, Md			
23a. BURIAL, CREMATION REMOVAL Burial		23b. DATE June 5		23c. NAME OF CEMETERY OR CREMATORY Crumpton		23d. LOCATION (City or Town) (County) (State) Crumpton Q.A. Maryland	
24. FUNERAL DIRECTOR Edgar Lane Church Hill, Md.				25a. REC'D BY REGISTRAR JUN 10 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



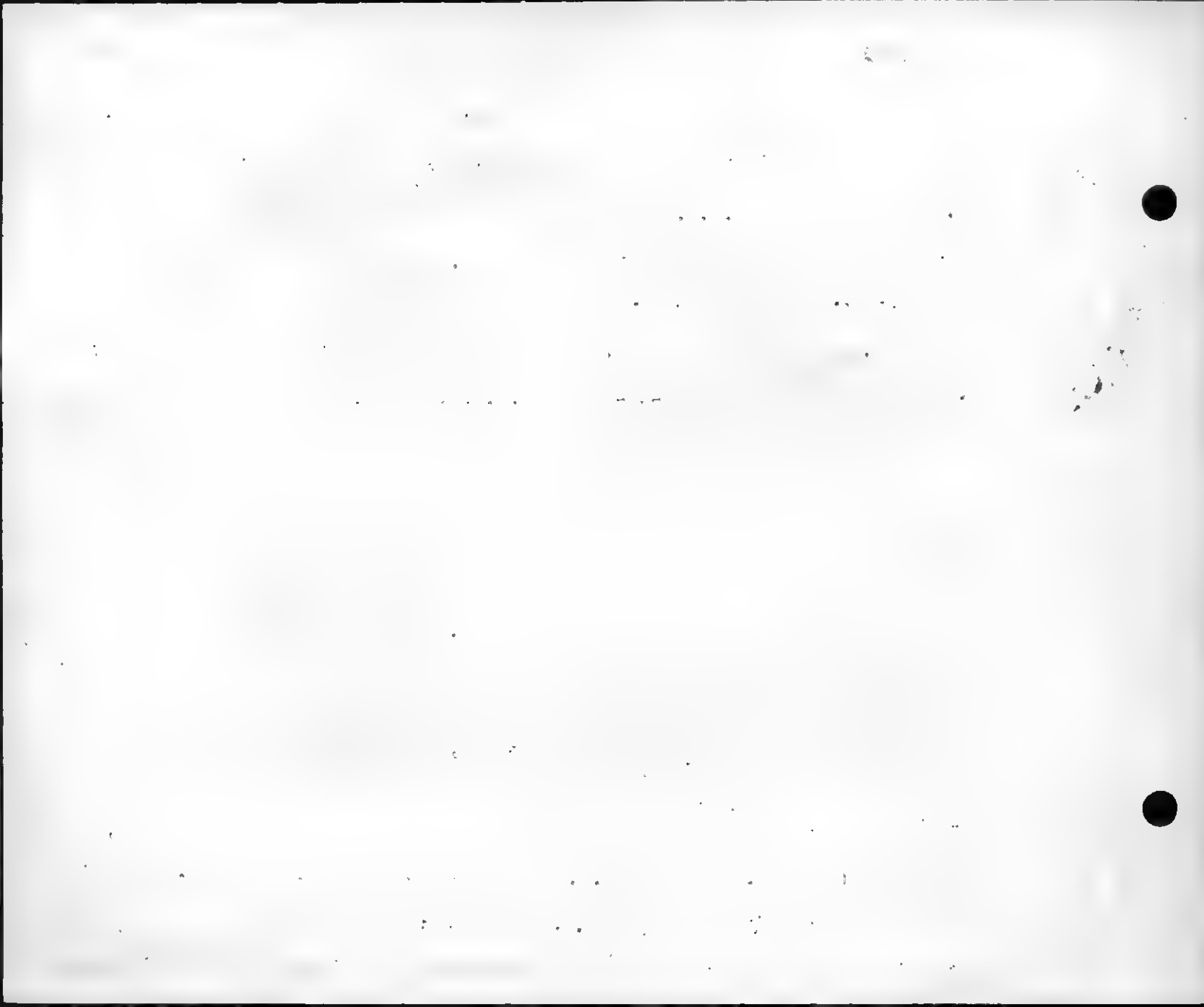
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They may remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A111
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR 11:10 A.M.		
ROBERT						SMITH		JUNE 17 1968					
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MAY 20, 1907				6. AGE (In years lost birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER Md							
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOS.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Middle Last ROBERT S. SMITH				15. MOTHER'S MAIDEN NAME First Middle Last FANNIE WOODS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNKNOWN		16b. SOCIAL SECURITY NO. 240-10-4066		17. INFORMANT Address E.S.S.H. RECORDS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from MAY 30, 19 67, to JUNE 17, 19 68, that (I) (we) last saw the deceased alive on JUNE 17, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Richard G. Bilodeau						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JUNE 17, 1968					
22d. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU, M.D.						22e. ADDRESS E.S.S.HOSPITAL, CAMBRIDGE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) REM.		23b. DATE 6/20/68		23c. NAME OF CEMETERY OR CREMATORY UNIV. ANATOMICAL Bld.			23d. LOCATION (City or Town) (County) (State) BALTIMORE BALT. MD.						
24. FUNERAL DIRECTOR Richard C. DePaie				ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

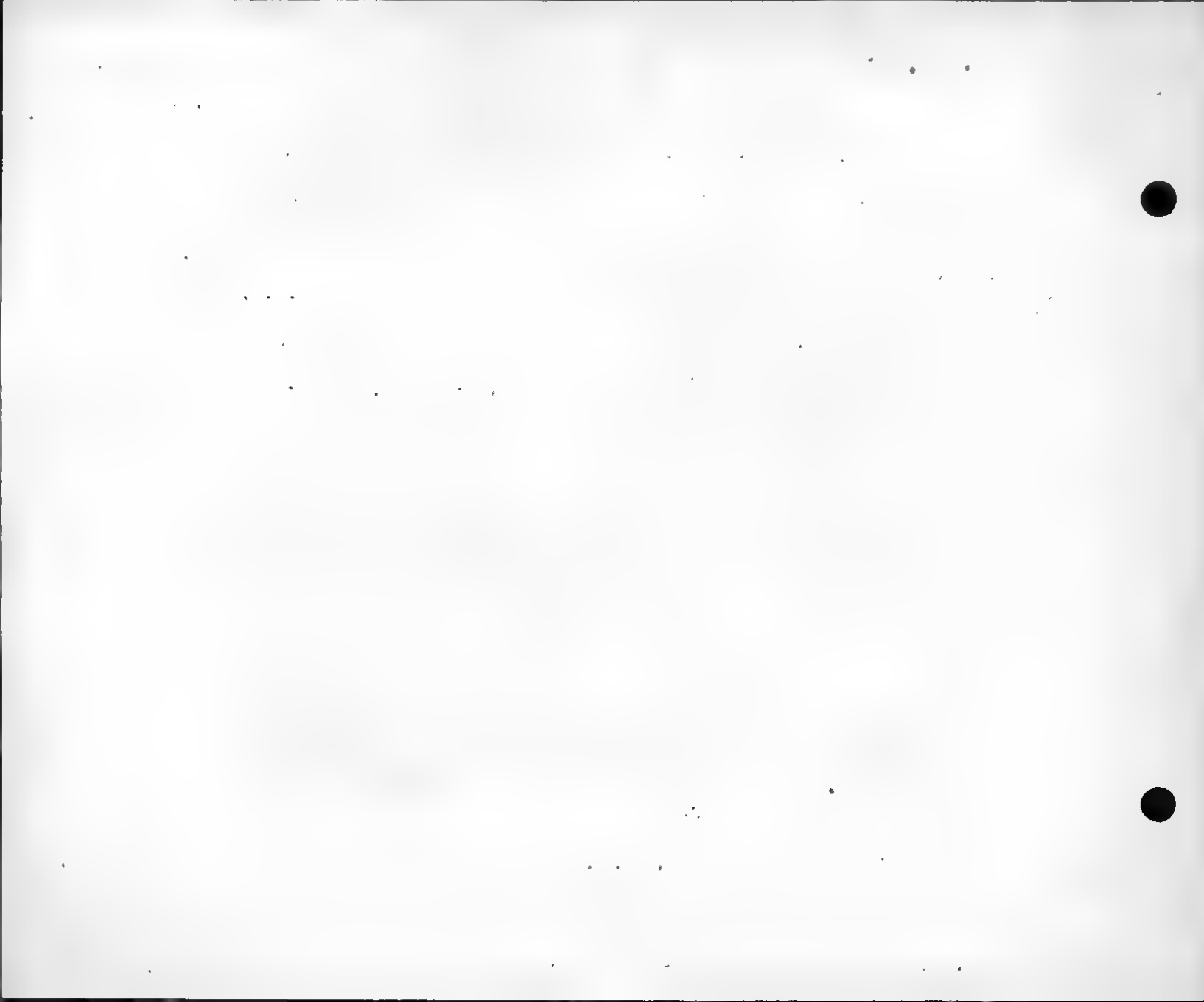
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year MATED <input type="checkbox"/> June 8 1968		2b. HOUR 4:15 P.M.
THOMAS		LEVIN		THOMPSON			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH April 29, 1914		6. AGE (in years last birthday) 54 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Vienna - Rural		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Near Rhodesdale		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Employee Dupont Co.		12b. KIND OF BUSINESS OR INDUSTRY Nylon	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R.F.D.		14. FATHER'S NAME First Middle Last Thomas R. Thompson		15. MOTHER'S MAIDEN NAME First Middle Last Lettie Baltimore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO. 214-07-9352		17. INFORMANT ADDRESS Mrs. Beulah M. Pinder, Vienna, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>420</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		M.D.		22b. DATE SIGNED 6/12/68 ADDRESS (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery		23d. LOCATION (City or Town) (County) (State) Rhodesdale, Maryland	
24. FUNERAL DIRECTOR <u>J. J. Frampton, and Son, Federalshurg, Maryland</u>				25a. REC'D BY REG STRAR DATE JUN 18 1968		25b. REG STRAR'S SIGNATURE <u>Charles Yager</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

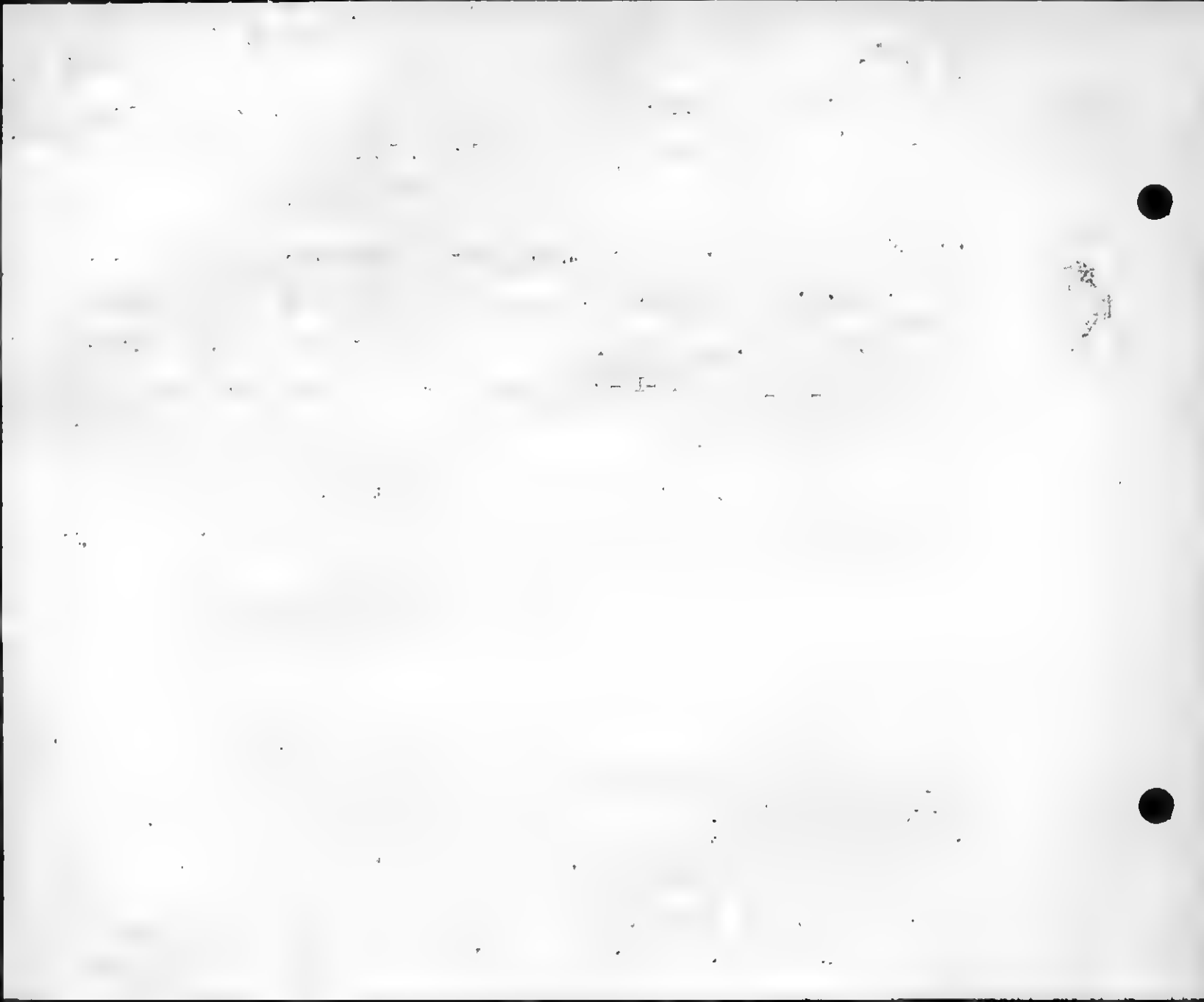
VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

58438

1 DECEASED-NAME (Type or print) First Middle Last ALMA BREESE TODD			2a. DATE OF DEATH Month Day Year June 24 1968			2b. HOUR M M			
3. SEX Female		4 RACE White		5 DATE OF BIRTH July 23, 1896		6. AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester Md.			
10 CITY OR TOWN OF DEATH Hatlock		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Belle Haven Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY - -			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 411 Robbins Street	
14. FATHER'S NAME First Middle Last Noah Lake Todd			15 MOTHER'S MAIDEN NAME First Middle Last Frances ? Insley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 212-16-7837		17 INFORMANT Address LeCompte Funeral Service records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Progressive cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 6 yrs 10 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Parkinsonism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/1/68 , 19 68 , to 6/23/68 , 19 68 , that (I) (we) last saw the deceased alive on 6/23/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE Charles P. Flumer H.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/23/68			
22d. PHYSICIAN'S NAME (Type) Charles P. Flumer H.D.				22e. ADDRESS Fr ton Mary; and Caroline					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR DATE JUN 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION ON



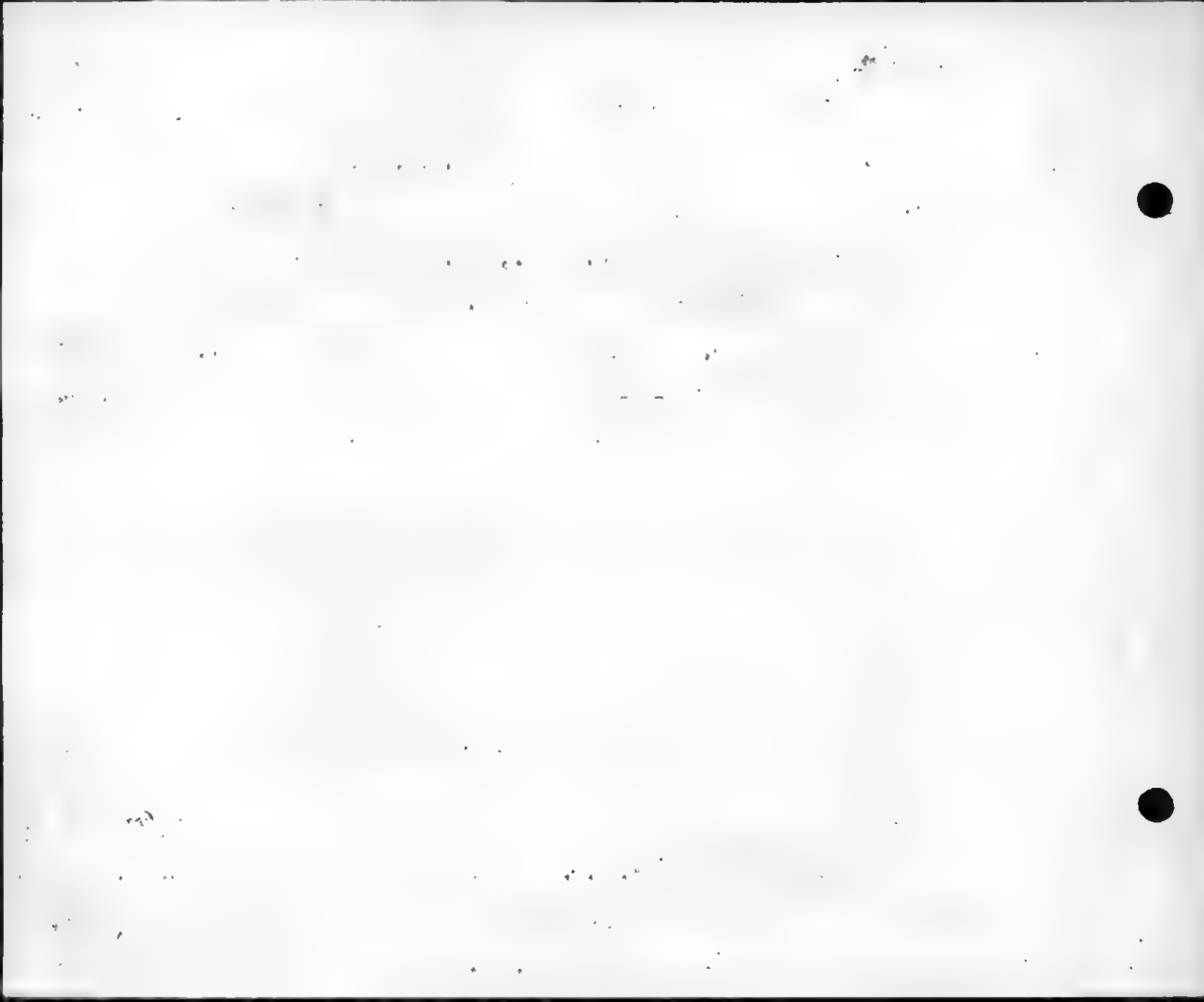
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) VIOLA BANKS TRAVERS			2a. DATE OF DEATH Month JUNE Day 11 Year 1968		2b. HOUR 8:20 A.M.
3. SEX FEMALE	4. RACE NEGROID	5. DATE OF BIRTH SEPT. 29, 1905		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH DORCHESTER		Md.			
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAMBRIDGE MD. HOSP., INC.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN LINAS RD.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RURAL			
14. FATHER'S NAME First Middle Last ANTHONY R. BANKS			15. MOTHER'S MAIDEN NAME First Middle Last SARAH J. BROWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-14-7348		17. INFORMANT Address CLARENCE TRAVERS CHURCH CREEK, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 1517 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/25/68 , 19 68 , to 6/11/68 , 19 68 , that (I) (we) last saw the deceased alive on 6/10/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence Maryanov		DEGREE M.D.		22c. DATE SIGNED 6/12/68	
22d. PHYSICIAN'S NAME (Type) LAWRENCE MARYANOV, M.D.		22e. ADDRESS 610 RACE STREET CAMBRIDGE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/16/68		23c. NAME OF CEMETERY OR CREMATORY LINAS ROAD Cemetery	
23d. LOCATION (City or Town) (County) (State) CAMBRIDGE, MD.					
24. FUNERAL DIRECTOR Frederick C. Delain		ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR JUN 12 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



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35123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

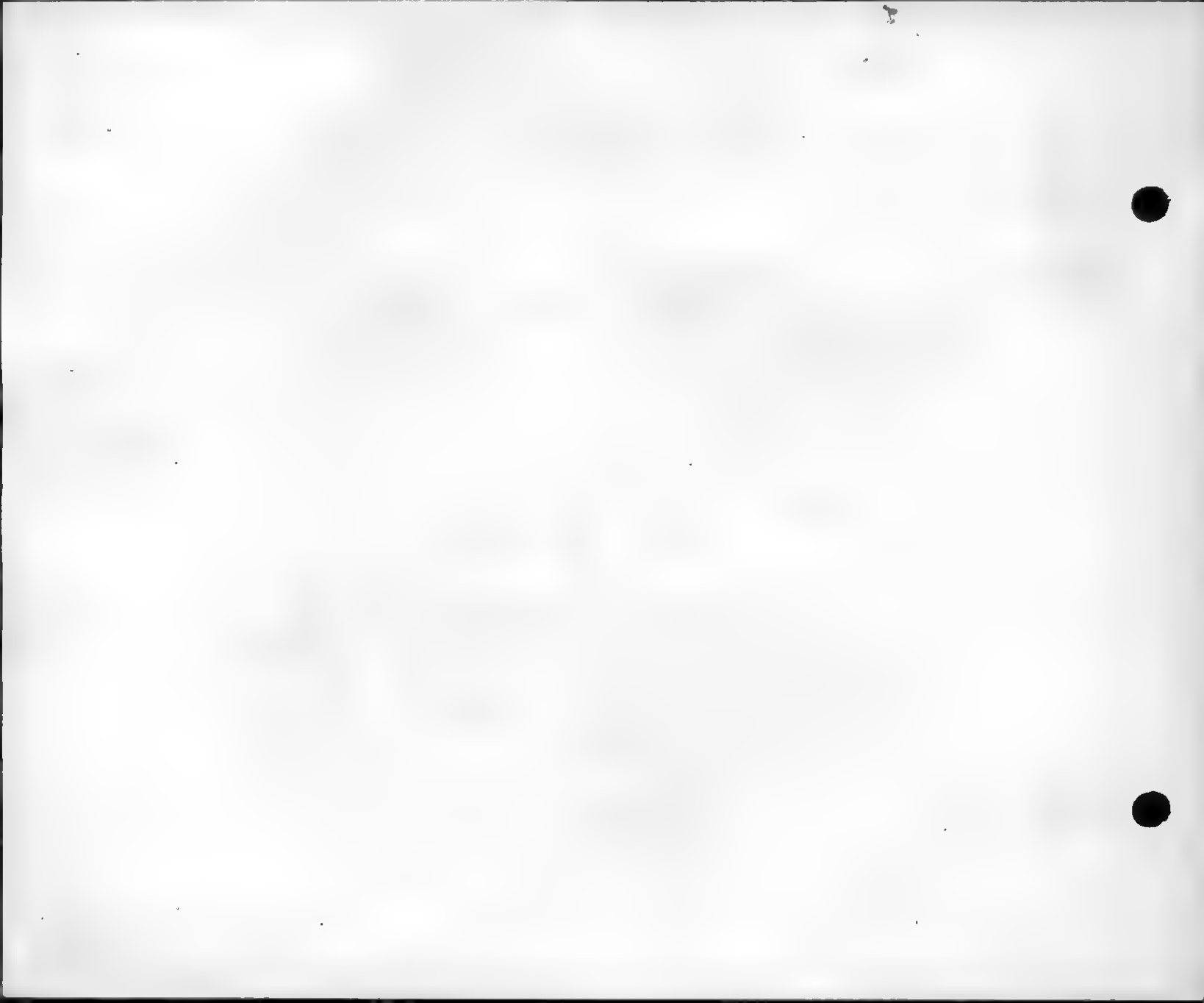
CERTIFICATE OF DEATH

35430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

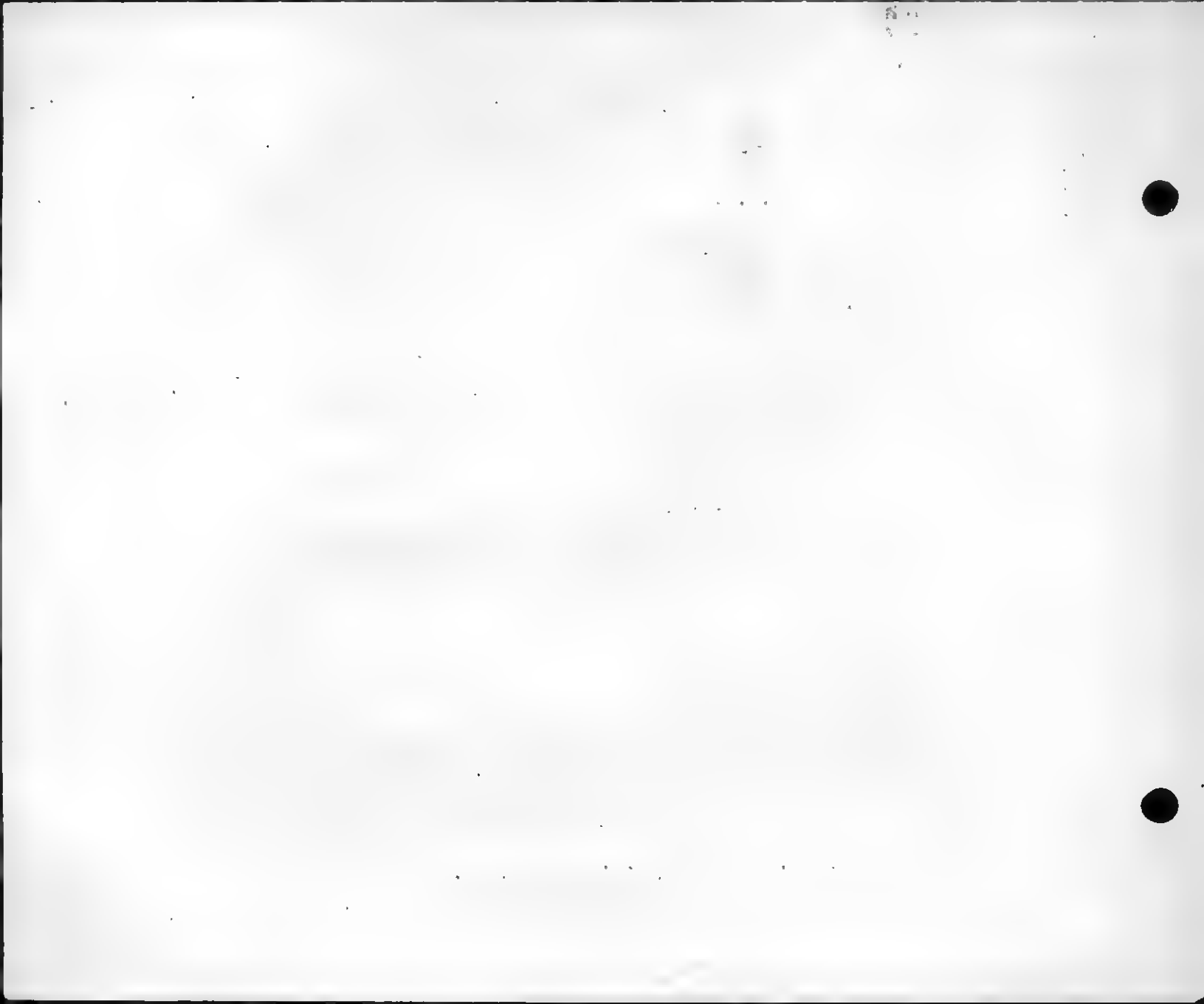
1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if first tut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN IT <u>26 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>NONE</u>			
3 NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>WALLS</u> Last <u>WALLS</u>				4 DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1968</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-20-92</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Walter Walls</u>				14. MOTHER'S MAIDEN NAME <u>Emma Merchin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>221-165478</u>		17. INFORMANT <u>Records of the Eastern Shore State Hosp.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, TERMINAL</u> <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>DIABETES MELLITUS</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u>	
PART II. OTHER SIGNIFIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u> </u> (this hospital) attended the deceased from <u>5-10-</u> , 19 <u>68</u> , to <u>6-4</u> , 19 <u>68</u> , that <u> </u> (we) last saw the deceased alive on <u>6-4</u> , 19 <u>68</u> , and that death occurred at <u>4:55 p.m.</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Miguel A. de la Guardia</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/4/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>MIGUEL A. de la GUARDIA, M.D.</u>				22d. ADDRESS <u>E. S. S. H.</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 8</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Templerville</u>		23d. LOCATION (City or Town) (County) (State) <u>Templerville, Md.</u>	
24. FUNERAL DIRECTOR <u>John E. Barakat</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 13e, Film G401 6 / MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) RUTH Mitchell Warren			2a. DATE KNOWN OF DEATH Month June Day 10 Year 1968			2b. HOUR 8:15 AM		2c. DATE PRONOUNCED DEAD Month June Day 10 Year 1968	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 3-14-1913	6 AGE (In years and birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		10 CITY OR TOWN OF DEATH Cambridge			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Eastern Shore State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laundry Work
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.			13b. COUNTY Dorchester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Unknown
14 FATHER'S NAME First Edward Middle Mitchell Last Marshall, Ruth			15 MOTHER'S MAIDEN NAME First Anna Middle Marshall Last Marshall			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown			
16b. SOCIAL SECURITY NO not listed			17. INFORMANT Medical Records Eastern Shore State Hosp.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE ASPIRATION OF FOOD PARTICLES FOLLOWING ATTEMPT AT DROWNING. (c) FOLLOWING ATTEMPT AT DROWNING.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7.10 X									
19a. DATE OF OPERATION 7.10 X			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Peter W. Rieckert			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 6-11-68
EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) EAST NEW MARKET, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/13/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD			
24. FUNERAL DIRECTOR Anna A. Penbaze				ADDRESS Berlin Md		25a. REC'D BY REG STRAR JUN 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15M (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY in 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E. S. S. H.</u>				d. STREET ADDRESS <u>Academy Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Charles J. Williams</u>				4. DATE OF DEATH Month Day Year <u>6 23 1968</u>			
5 SEX <u>m</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-21-80</u>	9 AGE (In years last birthday) <u>88 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min <u>1 1 1</u>		IF UNDER 24 HRS Hours Min <u>1 1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Williams</u>				14. MOTHER'S MAIDEN NAME <u>PACKS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-20-7205</u>		17. INFORMANT <u>Elsie Williams</u>		Address <u>Federalburg</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ischemic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>17 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>fell in hospital</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6 4/5/68</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Cambridge Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr</u>		EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Federalburg, Md.</u>		22. DATE SIGNED <u>6/23/68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Federalburg, Car. Md.</u>	
24. FUNERAL DIRECTOR <u>James Williams - Federalburg, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL - 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR 4-5-68
30M REV. 11/68

<div style="display: flex; justify-content: space-between;"> 08428 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 38433 </div>											
1. DECEASED-NAME (Type or print) WILLIAM HENRY WILMER						2a. DATE OF DEATH JUNE 6, 1968 Month Day Year			2b. HOUR 9:45 A.M.		
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 2/7/84			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER Md.					
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY TALBOT ✓		13c. CITY OR TOWN UNIONVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1, Box 238			
14. FATHER'S NAME First Middle Last WILLIAM WILMER				15. MOTHER'S MAIDEN NAME First Middle Last Jennie Wilmer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-12-6439		17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 485X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cachexia due to Cerebrovascular accident.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 68 , to 6/6 , 19 68 , that (I) (we) last saw the deceased alive on 6/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlos F Barroso MD DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-6-68							
22d. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO MD		22e. ADDRESS 5 Main St. Haverhill Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 16, 68		23c. NAME OF CEMETERY OR CREMATORY Richards Cem		23d. LOCATION (City or Town) (County) (State) EASTON Talbot Md					
24. FUNERAL DIRECTOR George H. Darbush Easton Md		ADDRESS		25a. REC'D BY REGISTRAR John Jones		25b. REGISTRAR'S SIGNATURE John Jones		DATE JUN 12 1968			

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[The main body of the document contains several paragraphs of extremely faint, handwritten text, which is largely illegible due to fading and bleed-through from the reverse side. The text appears to be organized into sections, possibly separated by horizontal lines.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08429

08434

1. DECEASED-NAME (Type or print) First Middle Last WILLIAM M WOOTTEN			2a. DATE OF DEATH Month Day Year JUNE 9 1968		2b. HOUR 7⁵⁰ PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 02-14-85		6. AGE (In years lost birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH DORCHESTER Md.		
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY Worcester	13c. CITY OR TOWN SNOW HILL	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER FEDERAL STREET	
14. FATHER'S NAME First Middle Last LUCEIN WOOTTEN		15. MOTHER'S MAIDEN NAME First Middle Last EMMA PARSONS WOOTTEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-16-1492		17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) EMPHYSEMA + CHRONIC BRONCHITIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 48 HRS. 5+ YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 5000 CACHEXIA + GENERALIZED ARTERIO SCLEROSIS.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/16 1967 to 06/09 1968 , that (I) (we) lost saw the deceased alive on 06/09 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sean M Killoran</i> M.D.		22c. DATE SIGNED June 9, 1968	22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN		
22e. ADDRESS 7415 BLAIR RD, WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6/12/68	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN	23d. LOCATION (City or Town) (County) (State) BERLIN W. MD.		
24. FUNERAL DIRECTOR <i>Anna A. Burbage</i>		25a. REC'D BY REGISTRAR JUN 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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